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## Implementation of the Dynamic Appraisal of Situational Aggression (DASA) Tool on Inpatient Mental Health Unit

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**Implementation of the Dynamic Appraisal of Situational Aggression (DASA) Tool on  
Inpatient Mental Health Unit**

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This Manuscript Partially Fulfills the Requirements for the  
Doctor of Nursing Practice Program and is Approved by:



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### Abstract

**Practice Problem:** Inpatient mental health units are vulnerable to aggression and violence, which may lead to physical injuries. It is essential to implement proactive measures to prevent violence before it escalates.

**PICOT:** In an adult inpatient mental health unit (P), does the use of the Dynamic Appraisal of Situational Aggression (DASA) (I), compared to no screening for aggression (C) decrease restraints and seclusion, provide early detection and awareness of aggressive behaviors (O) within ten weeks.

**Evidence:** The DASA assessment tool has been tested in various settings, such as forensic and general adult mental health units. It has also been found to have good internal consistency and inter-rater reliability.

**Intervention:** The Inpatient DASA screening tool was used for eight weeks. A pre/post-test was given to measure RN knowledge and perceptions of using the DASA.

**Outcome:** The DASA is an effective tool that predicted violence in those patients with a score of greater than four and resulted in a decrease in seclusion and restraints. 85% of the nurses participating perceived the DASA to be effective in identifying aggressive patients, and 92% would like to continue the use of the DASA.

**Conclusion:** The DASA is an evidence-based tool that can predict violence within 24 hours before its onset. It is easy, practical, and feasible for mental health units. The DASA allows the RN to identify those at higher risk and implement a treatment plan to mitigate those risks.

### **Implementing the DASA in a Mental Health Unit**

Aggression and violence in the inpatient mental health setting are challenging for staff and patients and can lead to physical injuries. Statistics of how often a nurse experiences workplace violence while trying to provide compassionate and high-quality care show that it is common in the workplace setting. According to the American Nurses Association (2021), one out of four nurses has experienced some form of workplace violence. The chances of allied healthcare employees being attacked are greater than those of police or corrections officers (ANA, 2021). Active preventative measures to stop violence before aggressive acts are necessary and have proven helpful (Amunrud & Bjorklund, 2022). There are many such preventative measures; however, the Dynamic Appraisal of Situational Aggression (DASA) is an assessment tool developed to anticipate the potential for violence to staff from patients (Ogloff & Daffern, 2006).

This scholarly project aimed to implement the Dynamic Appraisal of Situational Aggression (DASA) in an acute mental health unit to mitigate violence in the behavioral health unit. Although the DASA is valuable as an evidence-based, valid tool, can it be easily used to help increase awareness of an aggressive patient, implementing interventions before the patient becomes destructive?

### **Significance of the Practice Problem**

Workplace violence in healthcare is a significant concern for both state and federal governments, as well as a regulatory issue, according to the American Hospital Association (AHA), Center for Medicare and Medicaid Services (CMS), Occupational Safety and Health Association (OSHA) and The Joint Commission (TJC). Workplace violence (WPV) consists of physically and psychologically harmful actions that occur while employees are on duty. Workplace violence, as defined by the Occupational Safety and Health Association [OSHA], "is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior at work (2015, p. 1)." It ranges from threats and verbal abuse to physical assaults and

even homicide. According to Bureau of Labor Statistics data, 454 homicides occurred in the workplace in 2019, and in 2018, healthcare workers accounted for 73% of all nonfatal workplace injuries and illnesses because of violence. On average, 1.3 million nonfatal violent crimes occur annually in the workplace (Bureau of Justice Statistics, 2022).

Violence occurs more often in behavioral health settings than other patient care areas (Niu et al., 2019). Nurses working in mental health are 20 times more likely to experience physical violence and all forms of patient aggression than in regular medical-surgical units. Eighty-three percent of psychiatric nurses reported experiencing at least one form of workplace violence in the past 12 months (Niu et al., 2019). The Center for Medicare and Medicaid Services (CMS) mandates regulatory obligations to maintain a safe setting for patients, residents, and staff. To meet the regulatory standard, surveyors expect hospitals to have a process for identifying "high-risk patients." High-risk patients are those at risk for suicide or other forms of self-harm and those who exhibit violent behaviors toward others. Additionally, hospitals are expected to demonstrate what steps they are taking to minimize those risks (CMS, 2022).

Injuries caused by workplace violence (WPV) impact frontline staff in various ways, both physically and emotionally. For example, staff may have decreased confidence or feelings of hopelessness and helplessness. They may experience headaches, fatigue, or anxiety (Goldblatt et al., 2020). Exposure to WPV may cause intrusive memories, nightmares, and feelings of helplessness, similar to Post-Traumatic Stress Disorder in nurses (Goldblatt et al., 2020).

Workplace violence burden hospitals and healthcare systems with an estimated cost of \$4.2 million annually (Buterakos et al., 2020). Contributing to the annual cost are staff attrition, training new staff to replace those who leave, missed days of work, and use of workers' compensation benefits (Buterakos et al., 2020). These factors may also lead to staff burnout, decreased quality of care, and poor patient satisfaction scores (Buterakos et al., 2020).

Without a structured approach to assessing risk for violence, we are less likely to identify objective measures related to violence and aggression. Nurses' ability to recognize or

detect behaviors before escalating aggression can improve the management of such behaviors. The Dynamic Appraisal of Situational Aggression (DASA) is an evidence-based, valid, and reliable Violence Risk Assessment (VRA) tool. Tools such as the DASA allow for proactive interventions. The DASA is a seven-item risk VRA designed to assist with the appraisal of imminent aggression (Ogloff & Daffern, 2006).

### **PICOT Question**

The prevalence of violent incidents and their impact on patients and staff has led to an increased focus on tools for violence risk assessment (O'Rourke et al., 2018). Given the types of patients and rates of violence, this project aimed to implement an evidence-based intervention for violence risk assessment that is feasible in the practice setting. The project sought to answer the following PICOT question: In an adult inpatient mental health unit (P), does the use of the Dynamic Appraisal of Situational Aggression (DASA) (I), compared to no screening for aggression (C) decrease restraints and seclusion, provide early detection and awareness of aggressive behaviors (O) within ten weeks.

### **Population**

The population consisted of patients 18 years or older in a 24-bed acute care inpatient mental health unit. They identified as male or female and have been diagnosed with a severe mental illness such as depression, bipolar disorder, schizophrenia, or psychosis. Patients may also have had a comorbid substance use disorder. Legal status was voluntary or involuntary.

### **Intervention**

The DASA is a seven-item risk VRA designed to assist with the appraisal of imminent aggression (Barry-Walsh et al., 2009). The items on the DASA are scored a (1), which indicates the presence, or a (0), which suggests the absence of patient behaviors during the shift. A total score is calculated by summing the results of the seven items. A score of '0' suggests that the risk of violence is very low, '1-3' indicates a moderate risk of violence, and a score of '4-7'

indicates a high risk for a violent episode (Amunrud & Bjorklund, 2022; Barry-Walsh et al., 2009; Ogloff & Daffern, 2006).

### **Comparison**

Nurses' decision-making is to protect and improve the patient's well-being. According to deTantillo and De Santis (2019), "Nursing judgment is the culmination of education, experience, and insight, allowing nurses to execute the best action possible for patients (p.266)." The nurses in this project have used nursing judgment to determine aggressive behaviors without using a VRA.

### **Outcome**

Patient outcomes are "measurable or observed results in response to nursing interventions, recorded at specific times during or aftercare, indicating maintenance or stabilization of health status for clients (Liu et al., 2014. p. 71)." This project aimed to (a) increase awareness of aggressive behaviors before escalation, and (b) decrease restraints and seclusion.

### **Timing**

This project was completed within ten weeks, allowing sufficient time to implement and educate on DASA.

### **Evidence-Based Practice Framework & Change Theory**

The John Hopkins evidence-based practice model (JHNEBPM) guided this project proposal using the PET (practice question, evidence, and translation) framework, a problem-solving approach utilizing a practice question, identifying the evidence, and incorporating or translating it into practice (Dang et al., 2022). The practice was developed utilizing the PICOT format (population, intervention, comparison, outcome, and time); this approach helps refine what is observed, studied, or needs to be changed in practice. Once the question was formulated, search words from the PICO question become the search strategy. For this project, the example search words were "inpatient psychiatric hospital," "violence assessment tool,"



Dynamic Appraisal Situational Aggression," and "DASA." Lastly, the project's translation leads to a change in practice and resulting outcomes (Dang et al., 2022). The John Hopkins evidence-based practice model was used to evaluate the quality and appraisal of the evidence by categorizing the evidence by strength, type, and significant findings. Translating into practice is sustained after the project and becomes a usual practice in the behavioral health unit.

Implementing change is challenging. Using a change theory framework increases the likelihood of success. Applying Lewin's change theory alongside the JHNEBPM framework, especially during translation, will help guide and maintain practice change. Lewin's model of change has three steps: (1) Unfreezing at the present level requires a confrontation or re-education process, achieved through team building; (2) Moving to a new level requires developing new behaviors, values, and attitudes. (3) Refreezing the new level seeks organization stabilization at a new balanced state to ensure safety (Tran & Gandolfi, 2020, p.202).

Lewin's three-stage change model looks at the current practice as the status quo, a proposed process for change, and a desired outcome (Tran & Gandolfi, 2020). For example, the current practice (status quo) in the behavioral health unit is to intervene with an aggressive patient after an aggressive act without the benefit of a VRA tool. Education began with senior leadership, unit-based leadership, and nurses establishing a foundation for using a VRA. To start the unfreezing or moving, nurses in the behavioral health unit utilized the DASA to identify patients at high risk of becoming violent within 24 hours, initiate interventions before the aggressive act, and mitigate violence on the unit. Refreezing occurs as the DASA becomes part of the unit's functioning and process.

### **Evidence Search Strategy**

The integrative review was based on data collected through a literature search. The Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, PsycINFO, and Google Scholar were searched. The search strategy flowed from a combination of MeSH terms

and keywords, such as 'violence risk assessment,' 'inpatient violence,' 'violence screening,' 'violence checklist,' 'predict hospital aggression,' 'predict hospital violence,' and 'violence checklist. Other terms that were used were' Boolean terms (Violent or violence or aggressive or aggression) AND (Inpatient or hospital or psychiatric unit) AND (Adult) AND (risk assessment) AND (Violence).

The literature search was limited to English-language research articles published in academic journals between 2018 and 2023. Studies investigating violence in which nurses experienced violence from co-workers or patients' families were excluded from the review. Also excluded were patients under the age of 18 and patients not in a designated behavioral health inpatient setting.

### **Evidence Search Results**

A total of 1260 articles were identified through the search strategy. The number of articles was reduced to 1256 after duplicates were removed. Of these, 1233 records were excluded after reviewing the titles and abstracts of the studies. These articles were excluded because they did not measure violence in the psychiatric inpatient unit (n=1038), used the DASA tool in other hospital settings (n = 128), or measured violence in children or adolescents (n = 55). A total of 12 articles were selected for full-text assessments. After further evaluation, six articles were excluded due to needing to meet the criteria.

In total, six studies were included in this review. Four articles describe implementing the DASA in the mental health inpatient unit. One article describes the validity and reliability of four violent risk assessments; the other describes violence risk identification and assessment.

The Johns Hopkins Evidence Level and Quality Guide (Dang et al., 2022) was used and can be viewed in Appendix A. Pertinent findings from each article were identified and assigned a quality rating and level. Level 'B' was assigned if the source showed good quality, sufficient sample size, good study design, and relevant findings. The evidence summary included findings directly related to the PICO question and were of all of B quality.

### **Themes with Practice Recommendations**

Several themes emerged from the literature review. The first theme noted was that violence in health care is a significant concern, especially in mental health inpatient units. A second prominent finding is that the DASA is a valid and reliable tool for assessing imminent aggression. The final theme is that it is easy and has shown the feasibility of use in the mental health inpatient unit.

#### **Theme One: Violence in the Mental Health Inpatient Unit**

All articles describe violence in the psychiatric setting as challenging for healthcare providers (Amunrud & Bjorklund, 2023; DeSouza & Bleich, 2023; Lantta et al., 2016; Maguire et al., 2018; Yuniati et al., 2020). Aggression and violence terms are used interchangeably in the studies. Violent behavior comprises physical, threatening, and verbal violence (DeSouza & Bleich, 2023; Yunati et al., 2020). Experiencing serious mental illness is listed as a significant risk factor for violence (Anderson & Jenson, 2019; Niu et al., 2019). The US Bureau of Labor and Statistics (2018) reports that violent acts are the leading cause of occupational injuries in state-run psychiatric hospitals, with 38-69% higher rates than in other hospital settings. According to NIOSH (2020), 80% of psychiatric nurses feel unsafe in the workplace, and 25% have experienced disabling injuries due to patient assaults. Aggressive behaviors can occur in any healthcare setting; however, the majority have been reported in mental health (BLS, 2018), where, according to NIOSH (2020), an average of 69,500 nurses and patients are assaulted annually. Violent outbursts from patients to direct care persons result in physical injuries, missed workdays, burnout, and post-traumatic stress disorder from emotional and psychological harm (DeSouza & Bleich, 2023; Renwick et al., 2019). Mental health nurses are crucial in assessing, preventing, and managing aggression. Early detection and management of patients at the greatest risk of demonstrating violence and aggression are vital for maintaining the safety of both patients and staff members.

**Theme Two: DASA as a Valid and Reliable Tool**

The implementation of the DASA (Dynamic Appraisal of Situational Aggression) to identify risk for aggression or violence was developed to assist in short-term assessment (next 24 hours) of risk for imminent violence in mental health units (Ogloff & Daffern, 2006). The DASA comprises seven items: negative attitudes, impulsivity, irritability, verbal threats, sensitivity to a perceived provocation, easily angered when requests are denied, and unwillingness to follow directions. Assigning a '0' for absent behavior or a '1' for behavior is present to seven items (Ogloff & Daffern, 2006). Each item is scored for presence or absence 24 hours before the assessment. The summed results with a total of 0-1 equal a low risk, a 2-3 score is a moderate risk, and a score of 4 or greater represents a high risk for the patient to engage in violence or aggression within 24 hours (DeSouza & Bleich, 2023; Ogloff & Daffern, 2006).

Five studies included in the evidence summary (Appendix A) supported the validity of the DASA in measuring the risk of violence. The DASA has been validated across various settings, including forensic and general adult mental health units (Amunrud & Bjorklund, 2023; DeSouza & Bleich, 2023; Lantta et al., 2016; Maguire et al., 2018; Yuniati et al., 2020). Yuniati and colleagues (2020) found that psychiatric nurses' accuracy in predicting violence or aggression increased significantly using a structured measure such as the DASA. Nurses more accurately predicted patients at risk for violence when a structured measure was combined with clinical experience (Amunrud & Bjorklund, 2023; DeSouza & Bleich, 2023; Lantta et al., 2016). The DASA also demonstrated good internal consistency and inter-rater reliability (Maguire et al., 2018). Though studies demonstrating good to excellent predictive ability are solid and compelling, concerns regarding the reliability and the utility of the DASA remain due to small sample sizes in individual studies. The DASA has repeatedly exhibited good to excellent predictive accuracy for verbal and physical aggression toward staff in the short term (Yuniati et al., 2020). Yuniati et al. (2020) described the DASA as having moderate to reliable predictive

validity. The DASA was also viewed as clear, relevant, and applicable to clinical practice (Amunrud & Bjorklund, 2023; DeSouza & Bleich, 2023; Lantta et al., 2016). Evidence also suggested that early prediction and identification of patients at risk for aggression was correlated with decreased incidents of aggression and restraint use (DeSouza & Bleich, 2023; Maguire et al., 2018).

### **Theme Three: Feasibility and Ease of Use**

Numerous VRAs have been developed, including the Broset Violent Checklist, Violence Risk Screening- 10 (v-Risk 10), and the Historical Clinical Risk Management-20 [HCR-20] (Amunrud & Bjorklund, 2021). However, the DASA is more sensitive and accurate in predicting violent behaviors (Yuniati et al., 2020). Nurses thought the DASA was manageable and easy to use, and studies have also demonstrated that scoring the DASA took less than five minutes on average (Yuniati et al., 2020). They were more confident using the DASA than not having a VRA tool. Using the DASA also increased awareness of the potential for aggression or violence (DeSouza & Bleich, 2023; Maguire et al., 2018). The study by Maguire and colleagues (2017) also revealed that when the DASA "was completed, nurses intervened more frequently compared to days when no DASA was completed (p.e972)." The higher the DASA score, the greater the interventions were considered. Overall, nurses in the studies could use the DASA appropriately and consistently with little training.

The DASA is selected for this project, given a review of the evidence related to feasibility and ease of implementation and incorporation into work processes, validity and reliability, and anticipated acceptance by nurses and stakeholders.

### **Setting, Stakeholders, and Systems Change**

#### **Setting**

The project occurred in a small urban hospital's inpatient behavioral health unit in the Northeast. The setting is a not-for-profit healthcare system with ten hospitals in the Baltimore–Washington metropolitan area. In this behavioral health unit, patients are placed in seclusion for

an average of 860 minutes per month. The unit also experiences an average of 8 violent episodes per month, and patient-to-staff assault is around three per month. By implementing the DASA tool in the inpatient psychiatric unit, nurses can use a standardized assessment for aggression, which can positively impact care. This standardization tool can make nurses aware, based on a numeric score, of the need for alternative interventions to prevent aggressive or violent behaviors.

This hospital has an adult psychiatric inpatient unit with a 24-bed capacity for voluntary and involuntary patients, both males and females, age 18 years and older. The patient population experiences acute symptoms of at least one psychiatric condition, including depression, bipolar disorder, psychosis, schizophrenia, anxiety disorder, or a comorbid substance use disorder. Project participants included the unit's registered nurse (RN), who predicted violence based on unstructured clinical judgment. There were no foreseeable risks to any project participants. The RN assigned to each patient utilized the DASA each day shift and on admission.

### **Stakeholders**

Moran et al. (2017) suggest that key stakeholders' involvement highly influences project outcomes. The stakeholders involved in the implementation of this project were senior leadership, the director of nursing, staff nurses in the behavioral health unit, inpatient providers, and the patients on the unit. A SWOT analysis of this project can be found in Appendix C. The primary function of a multidisciplinary team (MDT) is to bring together a group of healthcare professionals from different fields to determine patients' treatment plans. The interdisciplinary approach to violence reduction is imperative to the project, as minimizing the occurrence of aggression or violence is a team approach in which the care plan can be determined to minimize risk.

## **System Change**

Although the system change occurred at the micro level unit, all the stakeholders benefitted from improved nursing knowledge, a better working environment, and the quality of care provided to mental health patients. It is anticipated that after the dissemination of the project, the DASA will be implemented at the macro level in all of the ten hospitals' behavioral health units.

### **Implementation Plan with Timeline**

Implementation of the DNP project required it to be achieved in clear and measurable terms. The SMART format (specific, measurable, attainable, realistic, and timed) is an excellent way to describe the project's objectives. The use of the DASA tool (1) increased nursing staff knowledge and confidence related to patient aggression and (2) decreased or reduced episodes of patients in restraints or seclusion by 10% after eight weeks of implementation.

The John Hopkins evidence-based practice model (JHNEBPM) guided this project proposal using the PET framework (Practice Question, Evidence, Translation), a problem-solving approach utilizing a practice question, identifying the evidence, and incorporating or translating it into practice (Dang et al., 2022). Lewin's model of change has three steps: (1) Unfreezing at the present level requires a confrontation or re-education process, achieved through team building; (2) Moving to a new level requires developing new behaviors, values, and attitudes; (3) Refreezing the new level seeks organization stabilization at a new balanced state to ensure safety (Tran & Gandolfi, 2020, p.202). Lewin's three-stage change model looks at the current practice as the status quo, a proposed process for change, and a desired outcome (Tran & Gandolfi, 2020). For an organization to change, the "unfreezing" of the status quo must happen. Unfreezing requires a re-education process achieved through team building. Moving to a new process requires the development of new behaviors, values, and attitudes. Refreezing will seek stabilization in the new state (Tran & Gandolfi, 2020).

This project's manager was intimately involved in the project's planning, scheduling, and implementation. There were no foreseeable risks to any project participants. The data collected from this project was kept in a double-locked cabinet in the project manager's office to maintain confidentiality and protect the project's integrity. The interdisciplinary team was essential to the project's success and was included during rounds, treatment team meetings, and huddles.

### **Unfreezing- Pre-Intervention**

Discussions were held with unit managers, staff nurses, and senior leadership in nursing, risk management, and quality regarding violence in the behavioral health unit two weeks before implementing the DASA. A pre-intervention survey was used for participants to identify their gender, the number of years they had worked with mental health patients, and the years they had worked in the current unit. Apart from these demographics, the project manager developed the pre-test survey and measured the nursing staff's confidence, knowledge, and perceptions of the DASA tool (see Appendix H). Two colleagues reviewed the questionnaire for face validity. Since the DASA tool alone will not hinder or stop violence from occurring, a discussion would also include the goal of using targeted aggression reduction interventions the nurse can use to mitigate aggressive or violent acts.

### **Moving- Intervention**

For nurses to successfully utilize the DASA, they are required to be educated regarding the value of violence risk assessment and accurately complete and score the tool. The first phase of the project implementation was to develop and deliver staff education about the DASA. Training and education are focused on presenting evidence to support using DASA. The training had a voice-over PowerPoint presentation (PPT) with written materials available to practice over the next two weeks (see Appendix F) explaining the use of the DASA tool. The PPT described how to identify patients at risk of becoming aggressive or violent, demonstrated how to complete and score the DASA, described the implementation plan of the DASA on the unit, and provided nursing interventions that can be initiated with a DASA score of four or greater.



The presentation also encouraged staff to communicate clearly with each other and the providers and reach out to security for safety needs. Sixteen nurses received the education from both shifts, as the DASA was completed on admission and then daily. The project took place for eight weeks, and the nurses completed the DASA on every admission and the day shift. Signage was posted inside the nurse's station to remind nurses to complete the DASA tool daily (See Appendix J & K).

### **Freezing- Post-Implementation**

Following the implementation of the DASA tool in the unit, a post-survey was conducted to evaluate nursing perception of the tool's impact (see Appendix I). The analysis revealed that the tool was viewed as highly beneficial, feasible, and easily adopted. As a result, it will be incorporated into the standard of care and integrated into nursing practice within the behavioral health unit.

### **Timeframe**

Implementing the DASA tool required a concise timeline while acknowledging that barriers may extend the initial goals. After the discussion with the stakeholders occurred, nurses received training regarding the DASA. The pre-test survey went out around the same time as training occurred. The survey and the training took approximately two weeks to complete. The actual DASA rollout and implementation took eight weeks, and data analysis took another two weeks. The timeline for the project was ten weeks.

### **Evaluation Plan**

The evaluation plan in this project sought to answer the PICOT question: In an adult inpatient mental health unit (P), does the use of the Dynamic Appraisal of Situational Aggression (DASA) (I), compared to no screening for aggression (C) decrease restraints and seclusion, provide early detection and awareness of aggressive behaviors (O) within eight weeks.

The implementation of the copyrighted DASA (Dynamic Appraisal of Situational Aggression) to identify risk for aggression or violence was developed to assist in short-term assessment (next 24 hours) of risk for imminent violence in mental health units (Ogloff & Daffern, 2006). The DASA comprises seven items: negative attitudes, impulsivity, irritability, verbal threats, sensitivity to a perceived provocation, easily angered when requests are denied, and unwillingness to follow directions. Assigning a '0' for absent behavior or a '1' for behavior is present to seven items (Ogloff & Daffern, 2006). Each item is scored for presence or absence 24 hours before the assessment. The summed results with a total of 0-1 equal a low risk, a 2-3 score is a moderate risk, and a score of 4 or greater represents a high risk for the patient to engage in violence or aggression within 24 hours (DeSouza & Bleich, 2023; Ogloff & Daffern, 2006).

The DASA assessment tool has been tested in various settings, such as forensic and general adult mental health units, by different researchers (Amunrud & Bjorklund, 2023; DeSouza & Bleich, 2023; Lantta et al., 2016; Maguire et al., 2018; Yuniati et al., 2020). It has also been found to have good internal consistency and inter-rater reliability (Maguire et al., 2018). The DASA has shown a sensitivity value of 69.2%, a specificity of 95.3%, a positive predictive value of 81.8%, and a negative predictive value of 91.1% (Yuniati et al., 2020, p. 2). The DASA measures dynamic and changing items, which can predict behavioral changes and the potential for violence or aggression (Amunrud & Bjorklund, 2022). [See Appendix E].

The following actions were taken after receiving copyright permission from the authors (see Appendix D) and getting IRB approval: The DASA tool was implemented daily for eight weeks on every patient admitted to the behavioral health unit. Each patient's chart had a paper version of the DASA placed in front of it. The DASA scoresheet contained one week's worth of data. Every week, the DASA scoresheets were collected and replaced with a new DASA form. If the patient was discharged before the seven days, the data sheets were collected on the day of discharge. Nurses highlighted patients identified as high risk for aggression or violence based

on a DASA score of equal or greater than four, and a communication was sent via Microsoft Teams to inform the treatment team to be aware of the risk. Demographics were collected for patients who scored four or greater. This information included sex, age, legal status (voluntary or involuntary), and diagnosis. No patient identifiers were used in this project. The data was secured in a double-locked cabinet in the project manager's office to ensure confidentiality and data protection.

The participants were invited to the training via email and fliers on the unit (see Appendix G). Registered nurses (RN) from both day and night shifts, approximately 16 RNs. The training was conducted for registered nurses (RNs) working day and night shifts. The RNs were invited to attend the training through emails and fliers. All sixteen RNs attended the training, of which 13 nurses participated and completed the education. Most of the DASA scores were collected during the day shift. All the nurses were required to complete the DASA score for every newly admitted patient to the unit. The training was conducted as a voice-over PowerPoint presentation (available in Appendix F), which covered various topics such as workplace violence, the importance of communication, how to score the DASA and interventions that may help mitigate aggression.

The implementation plan for DASA on the unit was also discussed during the training. After the training, an anonymous and voluntary survey was sent to all the participants through a HIPPA-compliant survey method (available in Appendix H). This survey included questions about the staff members' demographics, clinical judgment, and perceived readiness to use a risk assessment tool to predict violence and aggression. A post-survey was conducted after implementation of the training to determine if any change in knowledge and perception occurred (available in Appendix I). The survey that the project manager developed aimed to assess the participants' awareness of behavioral cues that predicted violence or aggression and their comfort level in assessing patients for admitted patients to the unit. Education was completed in the form of a voice-over PowerPoint presentation (see Appendix F) with information on violence

in the workplace, how to score the DASA, the importance of communication, and interventions that may help mitigate aggression. After this education, a voluntary and anonymous survey was emailed using a HIPPA-compliant method (Appendix H). This survey contained the staff member's demographics, questions regarding clinical judgment, and perceived readiness to use a risk assessment tool to predict violence and aggression. At eight weeks of implementation, a post-survey was sent to determine if a change in knowledge and perception occurred (Appendix I). The project manager developed the survey to assess the degree to which participants 1) are aware of behavioral cues that predicted violence or aggression, 2) are comfortable assessing patients for risk of violent or aggressive behavior, 3) believed their clinical judgment was accurate to determine the risk of violence and 4) believed VRA instruments were important in the prevention of violence. The post-test evaluated the degree to which participants found the DASA effective in identifying violence risk in patients and increasing awareness of behavioral cues for violence potential. Reminders for completion of the DASA were posted in the nurse's station and next to desktop computers (Appendix J & K).

### **Results**

This study aimed to assess the effectiveness of the DASA tool in detecting and preventing aggressive behavior in patients in an adult mental health unit. The findings are categorized into five main areas of inquiry: firstly, the positive correlation between patients' aggression and their DASA scores, shedding light on the sensitivity of the DASA and further validating the predictive accuracy of the DASA for inpatient aggression. Secondly, there is an absence of correlation between patients' diagnoses and their DASA scores, highlighting the impartiality of the DASA across diverse diagnostic spectrums. Thirdly, an analysis of instances where DASA scores exceeded four, emphasizing the tool's potential in identifying high-risk cases warranting proactive interventions; fourthly, a comparative exploration of nurses' trust in clinical judgment versus the DASA for assessing violence risk, revealing shifting perceptions post-DASA implementation; and finally, the impact of the DASA on restraint and seclusion.

Overall, the findings highlight the clinical impact of the DASA and the implications for additional research and improvements to enhance patient care and safety.

### **Correlation Between Aggression and DASA Score**

The results of the data analysis show a positive correlation between aggression and DASA scores; this suggests that the DASA is a reliable and sensitive tool for predicting aggression ( $p=0.001$ ), as shown in Table 1. Individuals with a DASA score of 4 or above are likelier to exhibit aggressive behavior. Conversely, those with DASA scores less than four are less likely to demonstrate aggression. While the DASA may not directly reduce violence or aggression in the workplace, it is essential to recognize and be aware of potential risks.

### **Correlation Between Diagnosis and DASA Score**

The initial findings suggest no correlation between the patient's diagnosis and their DASA score ( $p=0.056$ ); this is important because it indicates that the DASA score is not biased towards any specific diagnosis, which could be crucial for accurately assessing risk across different patient populations as seen in Table 2.

### **Analysis of High DASA Scores**

Out of the 116 DASA scoresheets that were completed, it was found that 23% of the patients had DASA scores exceeding four. The most common diagnoses were schizoaffective disorder (41%), Bipolar disorder (33%) followed by schizophrenia with 26%. Of note, 89% of the patients who scored four or greater were involuntarily admitted. Most of these cases were associated with aggressive behavior that required interventions, highlighting the potential usefulness of the DASA in identifying high-risk cases that may require proactive management strategies. The aggressive behaviors were mainly directed toward objects and involved verbally threatening behaviors, except for one instance of physical aggression against others. The interventions implemented included intermuscular medication administration, physical holds (restraint), and seclusion. It was also observed that eleven patients (41%) with a DASA score of 4 or higher had comorbid substance use (see Table 3). Given the impact of both mental illness

and substance use on aggression, it is essential not to take these issues lightly and explore them further.

### **Comparison of Clinical Judgement and DASA**

The pre-and post-tests to measure RN perception and knowledge of the DASA had a response rate of 81% for the pre-education survey and 68% for the post-implementation survey (See Table 4). Before implementing the DASA, nurses expressed more trust in their clinical judgment compared to a violence risk assessment tool. However, following the implementation of the DASA, there was a decrease of 12.5% in trust in clinical judgment, indicating that the DASA was perceived as superior for assessing the risk of violence or aggression. When asked if they believed a structured tool for violence is vital in preventing violence, those scores also increased by 12 % in the post-test. Nurses evaluated the DASA as an effective tool in identifying potentially aggressive patients; the DASA increased their awareness of behaviors that indicate a patient may become violent; nurses also thought that the use of DASA decreased the episodes of restraints and seclusions, and all but one nurse on the post-survey endorsed continued use of the DASA.

### **Impact of Restraint and Seclusion**

Implementing the DASA led to a reduction in the use of physical restraints (22%) and seclusion (36%), as well as a decrease in the total time patients spent in seclusion (64%), as seen in Table 5. However, there was a slight increase in the time patients spent in physical holds. Overall, these findings suggest that the DASA may contribute to a reduction in restrictive interventions and improve patient outcomes.

### **Clinical Significance**

In considering the clinical significance of these findings, it is essential to recognize the implications for patient care and safety within this project's setting. The absence of an evident correlation between diagnosis and DASA scores suggests that conventional diagnostic classifications may not adequately capture the complexities of aggression risk. The ability of the DASA to identify instances of aggression, particularly those requiring immediate interventions

such as IM injections or seclusion, underscores its value as a tool for the proactive management of aggressive behaviors. Furthermore, the shift in nurses' attitudes toward relying more on the DASA than clinical judgment for risk assessment signals a potential paradigm shift in approaches to violence prevention and management. However, the slight increase in the time patients spent in physical holds warrants further investigation into potential unintended consequences of DASA implementation and optimization of strategies to minimize restrictive interventions while effectively mitigating aggression. Overall, these findings highlight the significant role of the DASA in enhancing patient care and safety in clinical settings while emphasizing the ongoing need for refinement and exploration to optimize its utility and effectiveness.

### **Impact**

This project aimed to incorporate a tool for assessing the risk of violence into the nursing workflow so that nurses could better recognize and be aware of patients who may be at risk for violence. The overall impact was appreciated in the reduction in the use of physical restraints and seclusion. The incorporation of DASA has been demonstrated to have a positive benefit in the overall safety of patients.

### **Limitations**

This project had a few notable limitations due to its small sample size and the short time frame. Out of the 16 nurses, only 13 (approximately 81%) completed the DASA training, which was not mandatory. As a result, some patients did not receive a DASA score or an aggression/violence appraisal or may have been scored incorrectly. With continued usage, nurses' resistance to the new practice may decrease. Another limitation was that the DASA scoresheets were completed on paper and were not part of the electronic medical record (EMR). The lack of EMR integration may have contributed to decreased DASA usage. Compliance with DASA may increase if it is integrated into the EMR.

### **Future Opportunities**

Routine screening for violence using the DASA improved the identification and management of patients at risk for an aggressive or violent episode than by nursing clinical judgment alone. Notably, nurses felt that the DASA had decreased their use of restraint and seclusion measures and increased their awareness of behaviors that may indicate that a patient may become aggressive or violent. It was found that using the DASA as a routine screening for violence improved the identification and management of patients at risk for aggressive or violent behavior, compared to relying on nursing clinical judgment alone. Nurses reported that the DASA decreased their use of restraint and seclusion measures and increased awareness of behaviors that may indicate a patient's potential for aggression or violence.

The DASA could be more successfully implemented if nurse informaticists assisted in incorporating the tool into the electronic health record (EHR). Once integrated into the EHR, the DASA would be more accessible, and nurse managers could easily monitor for accurate completion. Clinical decision support to prompt users to specific clinical interventions based on a patient's DASA score could be developed to identify interventions that prioritize evidence-based interventions for patients at higher risk for aggression.

Education and training about violence and the use of VRAs should be provided to increase nurses' awareness and focus on the issue of patient violence. Furthermore, training about the DASA could be provided annually during onboarding and incorporated into existing face-to-face violence de-escalation training.

### **Dissemination**

After completion of the scholarly project, the results were shared with the facility, the School of Nursing, and the community. The first step was to invite all the facility's stakeholders, including upper leadership, nursing leadership, nursing staff, security personnel, providers, and others, to a Microsoft Teams video presentation on the project outcomes. Additionally, a summary of the DNP Scholarly Project was presented orally in a poster presentation. This



presentation is open for peers and instructors to view and provide feedback. The abstract was submitted to the American Psychiatric Nurses Association (APNA) for consideration for a presentation at the APNA 38<sup>th</sup> Annual Conference.

Finally, as a requirement of the DNP degree program, it is necessary to submit the full-text scholarly paper for publication in SOAR@USA. The manuscript was uploaded and submitted for publication at the Scholarship and Open Access Repository (SOAR@USA) at the University of St. Augustine for Health Sciences. The advantages of publishing the scholarly project in this open-access repository are numerous. Firstly, it is easily discoverable and available to the public, which enables other researchers to benefit from the knowledge and insights presented. Additionally, scholarly projects and research published in open-access repositories like SOAR@USA are more visible and cited more frequently than those published in closed databases such as ProQuest, making it a significant avenue for sharing research findings (University of St. Augustine Health Science n.d).

### **Conclusion**

Workplace violence is a significant concern. It ranges from threats and verbal abuse to physical assaults and even homicide. Violence occurs more often in behavioral health settings than in other patient care areas (Amunrud & Bjorklund, 2022; Niu et al., 2019). Mental health nurses are more vulnerable than their medical-surgical counterparts. Early detection and management of patients at the greatest risk of demonstrating violence and aggression are crucial for maintaining the safety of both patients and staff members. Regulatory agencies such as CMS and the Joint Commission require a process for identifying high-risk patients.

The DASA is an evidence-based tool that can predict violence within 24 hours before its onset. It is easy, practical, and feasible for mental health units. The DASA allowed the RN to identify those at higher risk and implement a treatment plan to mitigate those risks. Using the DASA increased their knowledge and perception of aggressive or violent behaviors and communication among team members about a potential risk of violence in the unit.

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**Table 1***Point Biserial Correlations for Aggression and Highest DASA Score*

<i>Combination</i>	<i>r</i>	<i>95.00% CI</i>	<i>n</i>	<i>p</i>
<i>Aggression-Highest DASA Score</i>	<i>-.80</i>	<i>[-.86, -.72]</i>	<i>116</i>	<i>&lt; .001</i>

The result of the correlation was examined based on an alpha value of .05

*Intellectus Statistics (2019) [Online computer software].*

**Table 2***Observed and Expected Frequencies of Diagnosis*

DIAGNOSIS	Aggression		<i>p</i>
	Yes	No	
Schizoaffective D/O	11[9.00]	25[27.00]	0.056
Bipolar D/O	9[6.50]	17[19.50]	
MDD	0[4.75]	19[14.25]	
Psychosis NOS	1[0.50]	1[1.50]	
OCD, personality schizoid	0[0.25]	1[0.75]	
Acute Stress	0[0.25]	1[0.75]	
cannabis-induced psychosis	0[0.50]	2[1.50]	
PCP Hallucinagenic dep	1[0.25]	0[0.75]	
antisocial PD	0[0.25]	1[0.75]	
Mood D/O	0[1.00]	4[3.00]	
Psychosis	0[0.25]	1[0.75]	
Anxiety	0[0.50]	2[1.50]	
Schizophrenia	7[4.50]	11[13.50]	
Brief psychotic break	0[0.50]	2[1.50]	

*Note.* Values formatted as Observed [Expected].

Intellectus Statistics (2019) [Online computer software].

**Table 3***Demographic of Patients with DASA Score 4 or Higher*

Sex	Male	13 (48%)
	Female	14 (52%)
Legal Status	Voluntary	3 (11%)
	Involuntary	24 (89%)
Diagnosis	Schizoaffective disorder	11 (41%)
	Bipolar Disorder	9 (33%)
	Schizophrenia	7 (26%)
Comorbid Substance use	Cannabis, PCP, Alcohol	11 (41%)
Median age		38.1 years



**Table 4**

*Pre and Post-Test Average Responses*

Question	Pre-Test Average	Post-test Average
I know behaviors that indicate a patient may become violent or aggressive.	4.53	4.4
I am comfortable assessing my patients for violent or aggressive behavior risks.	4.38	4.8
I am more accurate in using my clinical judgment to assess patients at risk for violence than a violence risk assessment tool.	4.23	3.7
I believe a structured tool for violence risk assessment is vital in preventing violence.	4.3	4.9
The DASA effectively identifies potentially aggressive/violent behaviors in patients.		4.9
The DASA increased my awareness of behaviors that indicate a patient may become violent or aggressive.		4.9
The use of the DASA decreased the episodes of seclusion or restraint with my patients.		4.5
I would like to continue to use the DASA as a violence risk assessment tool.		4.8

**Table 5**

*Seclusion and Restraint Results Pre- and Post-Implementation of DASA*

	September	October	Totals	Post Implementation	November	December	Totals
Number of Physical Hold (PH)	9	14	23		8	10	18
Minutes in PH	17 mins	23 mins	40 mins		15 mins	39 mins	54 mins
Number of Seclusion	4	7	11		5	2	7
Minutes in Seclusion	289 mins	676 mins	965 mins		234 mins	112 mins	346 mins

Appendix A

Summary of Primary Research Evidence

Citation	Design, Level Quality Grade	Sample Sample size	Intervention Comparison (Definitions should include any specific research tools used along with reliability and validity)	Outcome Definition	Usefulness Results Key Findings
<p>Amunrud, A., &amp; Bjorklund, P. (2022). Implementation of the dynamic appraisal of situational aggression in inpatient mental health. <i>Perspectives in Psychiatric Care</i>, 58(3), 1153–1159. <a href="https://doi.org/10.1111/ppc.12915">https://doi.org/10.1111/ppc.12915</a></p>	<p>Level V Quality improvement Grade- B</p>	<p>50 RNs 160 inpatient patients</p>	<p>Dynamic Appraisal of Situational Aggression (DASA) is a reliable tool with studies to support its reliability and validity. Pre/post-test measured RN's perceptions of DASA and increased knowledge of using a structured Violence Risk Assessment (VRA)</p>	<p>Yes, to pilot the feasibility of using a VRA on the inpatient psych unit. Increase RN knowledge in VRAs</p>	<p>Pre/post questionnaires measured RN knowledge and perception of DASA with + result. RNS was more confident in assessing for aggression</p>
<p>Anderson, K. K., &amp; Jenson, C. E. (2019). Violence risk–assessment screening tools for acute care mental health settings: Literature review. <i>Archives of Psychiatric Nursing</i>, 33(1), 112–119. <a href="https://doi.org/10.1016/j.apnu.2018.08.012">https://doi.org/10.1016/j.apnu.2018.08.012</a></p>	<p>Literature Review Level V Grade- B</p>	<p>29 Quantitative articles Three qualitative articles</p>	<p>Four different VRAs: BVC, DASA-IV, V-RISK-10, START.</p>	<p>All four VRAs were identified as assessments for violence.</p>	<p>Based on statistical information, only the BVC and the V-Risk-10 are</p>

					recommended for use in the acute MH unit.
DeSouza, F., & Bleich, M. (2023). A Quality Improvement Approach to Violence Reduction: Standardizing the Risk Identification Process. <i>Journal of Nursing Care Quality</i> . <a href="https://doi.org/10.1097/NCQ.00000000000000713">https://doi.org/10.1097/NCQ.00000000000000713</a>	Level V Quality improvement Grade- B	19 RNs	Implementation of the DASA vs no VRA tool	RNs can use DASA. Increase in risk identification by 69%, with a decrease in staff or patient aggression by 64% and 28%	Yes, it shows the effectiveness of using DASA.
Lantta, T., Kontio, R., Daffern, M., Adams, C. E., & Valimaki, M. (2020). Using the Dynamic Appraisal of Situational Aggression with Mental Health inpatients: a feasibility study. <i>Patient Preference and Adherence</i> , 691. <a href="https://doi.org/10.2147/PPA.S103840">https://doi.org/10.2147/PPA.S103840</a>	Level V Quality improvement Grade- B	RN=64 Patients=72	Feasibility of implementation of DASA across three different acute MH units. With patient participation via informed consent and 3 focus groups	Feasible to use in MH units. Patients had concerns about being rated.	Yes, it has implications for the feasibility of use and essential patient feedback.
Maguire, T., Daffern, M., Bowe, S. J., & McKenna, B. (2018). Risk assessment and subsequent nursing interventions in a forensic mental health inpatient setting: Associations and impact on aggressive behavior. <i>Journal of Clinical Nursing</i> , 27(5–6), e971–e983. <a href="https://doi.org/10.1111/jocn.14107">https://doi.org/10.1111/jocn.14107</a>	Level III Grade- B	Patients=60 Forensic MH	Looking at DASA and nursing intervention's impact on aggression	Nurses intervened more frequently when DASA was completed. The higher the DASA, the greater the interventions were used.	Yes, it shows nurses actively engaged in the DASA process and intervening to decrease aggression.

<p>Watt, K. A., Storey, J. E., &amp; Hart, S. D. (2018). Violence risk identification, assessment, and management practices in inpatient psychiatry. <i>Journal of Threat Assessment and Management</i>, 5(3), 155–172.  <a href="https://doi.org/10.1037/tam0000099">https://doi.org/10.1037/tam0000099</a></p>	<p>Mixed study Level III Grade- B</p>	<p>Small sample size- 1 or 2 representatives from each of the 13 inpatient unit</p>	<p>Focus groups with structured questions regarding Violent risk identification assessments.</p>	<p>Limited use of formal identification of violence assessments or use of VRA, diverse strategies to manage violence on the unit.</p>	<p>This study shows the need for VRA as well as managing violence in the unit.</p>
<p>Yuniati, Putra, &amp; Widasmara. (2020). Brøset Violence Checklist (BVC) versus Dynamic Appraisal of Situational Aggression-Inpatient Version (DASA-IV): their sensitivity, specificity, and accuracy as a predictor of violence in 24 hours among schizophrenia patients. <i>Medisains</i>, 18(2), 58–62.  <a href="https://doi.org/10.30595/medisains.v18i2.7454">https://doi.org/10.30595/medisains.v18i2.7454</a></p>		<p>112 patients with a schizophrenia diagnosis</p>	<p>Comparing the broset violence checklist against the DASA as a predictor of violence within 24 hours</p>	<p>The DASA was more sensitive with higher specificity and more accurate in predicting violence than BVC.</p>	<p>This study will help discuss why DASA vs. BVC is so essential and also the validity of DASA.</p>

Legend: BVC (Broset violence Checklist); DASA-IV (Dynamic Appraisal of Situational Aggression IV (Inpatient Version)); VRA (Violent Risk Assessment); MH (Mental Health); START (Short Term Assessment of Risk and Treatability); V-RISK-10 (Violence Risk Screening 10)

## Appendix B

**Timeline**

Action Item	Responsible party	Time frame
Discuss workplace violence and the need for a DASA tool	Project manager	1 week
Ensure Training and educate nurses on DASA	Project manager, staff educator, DON	2 weeks
A survey will be sent out to nurses	Project manager	2 weeks together with training
Implementation of DASA	Project manager, DON, Educator	8 weeks
Analysis of data	Project manager	1-2 weeks

## Appendix C

### SWOT ANALYSIS

#### INTERNAL FACTORS

STRENGTHS +	WEAKNESSES –
<ul style="list-style-type: none"> <li>• Evidence-Based Practice is valued</li> <li>• Data supports need for change</li> <li>• Support of Leadership</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of Structured Assessment Tool</li> <li>• Change Process Can Be Slow</li> <li>• Nursing skeptical of Change</li> </ul>

#### EXTERNAL FACTORS

OPPORTUNITIES +	THREATS –
<ul style="list-style-type: none"> <li>• Implementation of a VRA on every admission and every shift</li> <li>• Desired outcomes</li> <li>• Improve Nurse/Staff Safety</li> </ul>	<ul style="list-style-type: none"> <li>• Approval from Author to use the VRA Tool (DASA)</li> <li>• Cost of the Tool</li> <li>• Delay In Implementation</li> </ul>

## Appendix D

## DASA Permission to use

From: Maira Rodriguez May 30, 2023

Good day, Sir,

I am a DNP student and currently work as the executive director of behavioral health for a hospital with a 24-bed unit treating voluntary and involuntary patients 18 years and older. We have had staff that suffered serious injuries due to aggression.

The staff does not currently use a violence risk assessment tool but is using clinical judgment to assess for aggression. I would like to introduce the DASA tool as it is a valid and reliable tool. I am having difficulties locating how to be granted permission for the tool. I will also be using the DASA for the DNP project. I would appreciate it if you could point me in the direction of permission for the DASA tool.

Thank you very much for your time and consideration.

Maira Rodriguez, MS, RN, PMH-BC, CNE

Michael Daffern May 30, 2023

Dear Maira

Thank you for your email.

You are welcome to use the DASA in your service. We ask that you purchase a copy of the manual from our university bookshop:

<https://booklist.bookshop.swin.edu.au/search.cgi?STYPE=KW&STEXT=dasa>.

For international purchases, please select the option for Shipping Quote. Someone from the bookshop will then contact you to provide a quote for shipping.

You can download the rating guide and access some other information freely here:

<https://www.swinburne.edu.au/research/centres-groups-clinics/centre-for-forensic-behavioural-science/our-publications-products/dasa/>

We have also developed an online DASA training program. The DASA online training program consists of five modules. Each module contains a video and a quiz. Participants are required to satisfactorily complete each quiz before they can progress onto the next module. At the end of the program, participants will receive a certificate. You should allow one hour to complete the training. The enrolment fee is \$30(AUD) per person. We are happy to discuss a discount for bulk enrolments. The training program can be accessed via the following link -

<https://dasa.thinkific.com/>

Completion of the training is not compulsory.

Finally, we have developed an aggression prevention protocol that is linked to DASA:

<https://www.swinburne.edu.au/research/centres-groups-clinics/centre-for-forensic-behavioural-science/our-publications-products/app/>

Finally, we are always keen to hear how services use the DASA and any evaluations of its performance. Please feel free to let me know how it performs in your service.

I hope this is helpful. I am happy to assist in any way I can.

It might be easier to contact me by email in the future: [mdaffern@swin.edu.au](mailto:mdaffern@swin.edu.au)

All the best

Michael



From: Maira Rodriguez May 31, 2023

Good evening,

Thank you for your prompt response! I will be sure to buy the manuscript.

As I get closer to the implementation of the DASA and findings, I'll be sure to share the results.

Thank you again.

Maira

Appendix E

Data Collection Tool for Evaluation



**DYNAMIC APPRAISAL OF SITUATIONAL AGGRESSION**

Name: \_\_\_\_\_

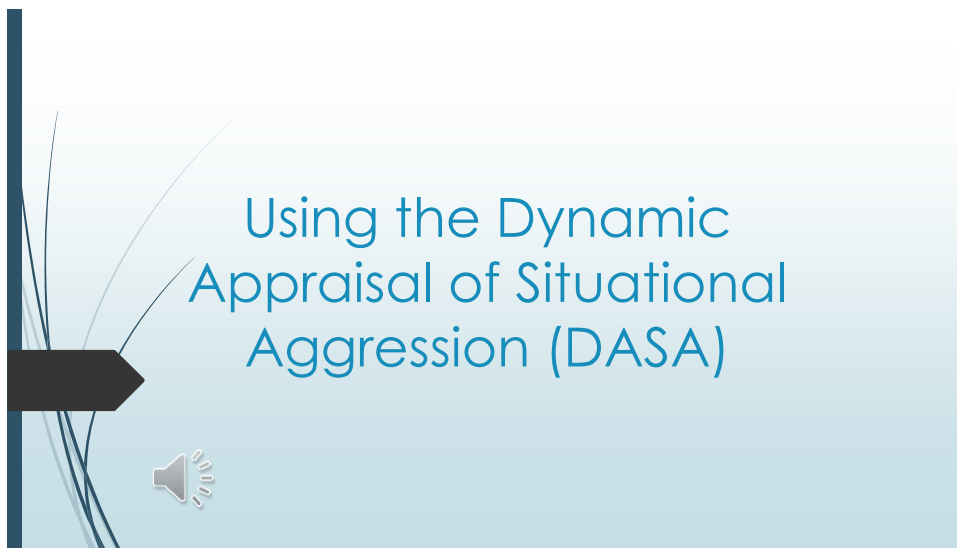
Week beginning: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

The following ratings are based on your knowledge and observations of the patient during the PREVIOUS 24 HOURS. Well-known patients are scored a 1 for an increase in the behaviour described, the patient's usual behaviour while being non-violent is scored as 0.	Monday <i>(Circle One)</i>	Tuesday <i>(Circle One)</i>	Wednesday <i>(Circle One)</i>	Thursday <i>(Circle One)</i>	Friday <i>(Circle One)</i>	Saturday <i>(Circle One)</i>	Sunday <i>(Circle One)</i>
<b>Irritability</b> The patient is easily annoyed or angered. The patient is unable to tolerate the presence of others.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
<b>Impulsivity</b> The patient displays behavioural and affective instability (i.e., dramatic fluctuations in mood, or general demeanour; inability to remain composed and directed).	0 1	0 1	0 1	0 1	0 1	0 1	0 1
<b>Unwillingness to Follow Directions</b> The patient tends to become angry or aggressive when they are asked to adhere to treatment or to the ward's routine.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
<b>Sensitivity to Perceived Provocation</b> The patient tends to see other people's actions as deliberate and harmful; they may misinterpret other people's behaviour or respond with anger in a disproportionate manner to the extent of provocation.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
<b>Easily Angered When Requests are Denied</b> The patient tends to be intolerant, or is easily angered when they make a request that is denied or when they are asked to wait.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
<b>Negative Attitudes</b> The patient displays antisocial and negative attitudes and beliefs which may relate to violence and aggression.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
<b>Verbal Threats</b> The patient displayed a verbal outburst, which is more than just a raised voice, and where there is a definite intent to intimidate or threaten another person.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
<b>Total</b>	<b>17</b>	<b>17</b>	<b>17</b>	<b>17</b>	<b>17</b>	<b>17</b>	<b>17</b>
<b>Final risk rating</b> <i>Based on the DASA score and clinical assessment rate (H) high, (M) medium or (L) low risk for the next 24 hours.</i>							
<b>Record of aggression</b> <i>During the previous 24 hours has the patient behaved aggressively in any of the following ways? (Please mark with a cross in the appropriate box)</i>							
<b>Physical Aggression against OBJECTS</b> Slams door, throws objects down, kicks furniture, breaks objects, smashes windows, sets fires, throws objects.							
<b>Verbal Aggression against OTHER PEOPLE</b> Shouts angrily, insults, curses viciously, uses foul language in anger, or makes clear threats of violence to others.							
<b>Physical Aggression against OTHER PEOPLE</b> Makes threatening gesture, swings at people, grabs at clothes, strikes, kicks, pushes, pulls hair, or attacks others.							

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## Appendix F

**Link to PowerPoint**



## Appendix G

Hello All,

We will begin piloting the violence risk assessment tool, called the Dynamic Appraisal of Situational Aggression (DASA), conducted by (name of team member). Please view the brief PowerPoint to assist you in completing the DASA daily. After viewing the PowerPoint, please take the five-question anonymous survey regarding the DASA.

The survey scores will be anonymous and not connected to performance evaluations. The PowerPoint should not take more than 5-10 minutes to view.

I appreciate your participation in this project.

Thank you,

XXXXXXXXXXXXXX

## Appendix H

**Pre-Post Education Survey****CODE:** \_\_\_\_\_

(Please list the unique code you created for the Pre-Education. This code consists of your mother's first and last initial and your 4-digit year of birth (e.g., EM1988). This code will be used to match your pre- and post-survey responses anonymously).

**Demographics**

I identify my gender as: \_\_\_\_\_

I have \_\_\_\_\_ experience as an RN working with mental health patients.

I have \_\_\_\_\_ years working in this unit.

I have been an RN for \_\_\_\_\_ years.

**Questions- Please circle your answers (1 is strongly disagree, 3 is neutral, and 5 is strongly agree)**

1. I know behaviors that indicate a patient may become violent or aggressive.

**1 2 3 4 5**

2. I am comfortable assessing my patients for violent or aggressive behavior risk.

**1 2 3 4 5**

3. I am more accurate in using my clinical judgment to assess patients at risk for violence than a violence risk assessment tool.

**1 2 3 4 5**

4. I believe a structured tool for violence risk assessment is vital in preventing violence.

**1 2 3 4 5**

5. I am able to communicate ideas, opinions, and concerns regarding risk assessment and management to nursing management.

**1 2 3 4 5**

## Appendix I

**Post-Implementation Survey Questions****CODE:** \_\_\_\_\_

(Please list the unique code you created for the Pre-Education. This code consists of your mother's first and last initials and your 4-digit year of birth (e.g., EM1988). This code will be used to match your pre- and post-survey responses anonymously).

**Please circle your answers (1 is strongly disagree, 3 is neutral, and 5 is strongly agree)**

1. I know behaviors that indicate a patient may become violent or aggressive.

1      2      3      4      5

2. I am comfortable assessing my patient for violent or aggressive behavior risk.

1      2      3      4      5

3. I am more accurate in using my clinical judgment to assess patients at risk  
for violence than a violence risk assessment tool.

1      2      3      4      5

4. I believe a structured risk assessment is vital in preventing violence.

1      2      3      4      5

5. The DASA effectively identified potentially aggressive/violent behaviors in  
patients.

1      2      3      4      5

6. The DASA increased my awareness of behaviors that indicate a patient may become violent  
or aggressive.

1      2      3      4      5

7. Use of the DASA decreased the episodes of seclusion or restraint with my patients.

1      2      3      4      5

8. I would like to continue to use the DASA as a violence risk assessment tool.

1      2      3      4      5

Appendix J  
**DASA Daily Reminders**



## Appendix K



**DID YOU DO THE  
DASA TODAY?**