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Article

Theorising Dementia as a Risk Classification: Sociotechnical Imaginaries of Safety and Order in Acute Hospital Care of People Living with Dementia

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Highlights

Public health relevance—How does this work relate to a public health issue?

- People living with dementia occupy roughly a quarter of NHS acute hospital beds, yet the routine safety measures used on these wards—restraint, sedation, one-to-one surveillance—remain poorly understood as a public health issue in their own right.
- Drawing on over 180 days of ethnographic observation and 1,168 in situ interviews, this study shows how everyday ward safety practices, not just clinical need, shape the care and risk of harm experienced by hospitalised people living with dementia.

Public health significance—Why is this work of significance to public health?

- The paper introduces dementia as a 'risk classification ', demonstrating how institutional imaginaries of an orderly ward led staff to treat dementia-related behaviours as risks to be pre-emptively contained rather than needs to be met. It reveals a self-reinforcing loop in which restrictive practices, justified by prevention and risk management, increase patient distress, which in turn prompts further restriction.

Public health implications—What are the key implications or messages for practitioners, policy makers, and/or researchers in public health?

- Metrics around fall prevention and safety-metric frameworks should be re-examined, as they can incentivise restrictive practices that harm the populations they were introduced to protect.
- Policy and practice should move toward person-centred conceptions of ward safety, and future research should track the long-term impact of restrictive practices on well-being and care trajectories across admissions and beyond discharge.

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Abstract

People living with dementia are one of the populations most at risk of restrictive intervention during an acute hospital admission. These restrictive interventions are typically justified by staff concerns about patient safety and as a means of mitigating against falls, itself a key metric of quality care in acute settings. Drawing on Jasanoff and Kim's concept of sociotechnical imaginaries, this paper explores how healthcare professionals imagine risk and safety, and how these imaginaries contour the use of restrictive practice. Data collection comprised 225 days of ethnographic observation and 1168 in situ interviews with patients, families, and ward staff at (n = 6) NHS Trusts working in (n = 3) dyads for acute and mental health care across England. Data were analysed thematically using NVivo. Findings were grouped into three major themes: *institutional cultures*, *institutional*

anxiety, and *atrocity stories.* The study reveals tensions between ways in which people living with dementia respond to admissions and the institutional imaginaries of a safe, risk-free ward, alongside expectations of "good patienthood." It argues that these imaginaries produce dementia as a risk classification, where bed or bedside-bound patients who do not demand staff attention inform the routine use of restrictive practices. These interventions, however, often result in distress and feelings of imprisonment among people living with dementia, which in turn prompts further tightening of restraints on this vulnerable population.

Keywords: dementia; restraint; restrictive practice; risk; ethnography

1. Introduction

People living with dementia (PLWD) constitute a significant proportion of patients admitted to acute medical settings in the United Kingdom's National Health Service (NHS). Formal statistics suggest that PLWD occupy about one in six NHS beds in acute hospitals [1], though this can be as high as one in four in some areas [2,3]. However, these figures significantly underestimate the true prevalence. Recent research on the experiences of PLWD in acute hospital settings indicates that the proportion of patients living with dementia in some settings could be as high as half of all admissions [4,5]. Notably, these admissions are typically for preventable conditions such as pneumonia, urinary tract infections, and falls [6] rather than dementia itself.

Directing analytical attention to these settings is crucial, as existing research portrays admission to these settings for PLWD as both 'challenging' [7] and 'dangerous' [8]. Dementia is a term encompassing a range of cognitive impairments typified by gradual decline in cognitive function that can disrupt individuals' ability to navigate unfamiliar spatial milieus [9,10]. At the same time, the organisation of care practices within these wards are not designed to accommodate patients with dementia [11], despite their high prevalence. As such, once admitted to these settings, PLWD are left at a significant risk of adverse events, including incontinence [12], reduced mobility [13], increased agitation [14], delirium [15], prolonged admission [16], and distress [17]. These in turn result in further dependency, institutionalisation, and even death during or following an acute admission [18].

These adverse events often stem from the acute admission itself, particularly due to expectations that patients conform to ward routines [11]. PLWD frequently exhibit behaviours staff perceive as challenging [19] and are often categorised as posing risks to themselves, others, and ward performance metrics, thereby disrupting the ward's smooth functioning [5]. In response, staff reinforce and 'tighten' control over PLWD [5,20]. This transcends Goffman's (1961;1967) total institution to the observable [21], prioritising routine, control, and risk management over the will of the person [19]. Against this backdrop, our analysis explores the mechanisms through which restrictive practices emerge as tools of control in managing and addressing institutional health and safety concerns within these settings.

Safety and Risk in the Context of PLWD during a Hospital Admission

There has been significant sociological interest in the concept of risk [22,23] since Ulrick Beck's [24] thesis of risk society. Beck's observations about structural shifts in risk perception and management are particularly relevant to the care of PLWD during a hospital admission, as this paper will elaborate. Modern institutions are increasingly oriented towards anticipation and mitigation, with governance of potential harms central to

organisational understandings. For groups such as PLWD, the diagnosis itself becomes a classification of risk, which in turn carries significant connotations within a tightly bound institutional setting, such as a hospital admission.

The mitigation of risk has moved far beyond its industrial roots [25,26]. It is within the clinical setting of the hospital as an institution that this paper argues it may reach its apex. This expansion of risk governance into ward environments extends beyond health and safety to the transformation of how patient groups, diagnosis, and classifications are perceived and responded to. We argue that this is felt most acutely by PLWD, who are understood not as patients, but as a diagnostic classification to be seen through a lens of institutional risk: their behaviours, temporalities, and care needs are interpreted not solely as clinical nor person-centred phenomena, but rather as potential threats to safety metrics, workflow, and organisational accountability.

To better understand these shifts and their implications within hospital environments, we draw on Jasanoff and Kim's [27] concept of sociotechnical imaginaries. This is because these changes did not meet a vacuous health and safety setting in hospitals; rather, they entangled and reshaped an already established and actively performed sociotechnical imaginary of health and safety management. As these imaginaries merged with contemporary risk governance, they helped bring dementia into the category of risk.

2. Imaginaries of Health and Safety on Hospital Wards and Cultures of Containment

Within contemporary acute hospital wards, health and safety has become a key metric of 'good' care. Patient management is often linked to falls, 'adverse events', and preventable patient safety issues such as pressure ulcers. Estimates suggest that approximately 240,000 falls are reported each year in the NHS, making falls one of the leading causes of hospital-acquired injuries [28], predominantly affecting older patients [29,30]. According to the National Patient Safety Agency, for every 1000 bed days in acute hospitals, there are in the range of 5–18 falls, with contributing factors often associated with cognitive impairment, including dementia and delirium, as well as continence and medication issues [31].

Concerns about risk in the care of PLWD are not without reason. For example, there are documented cases of patient deaths and/or serious harm following incidents commonly referred to as 'absconding', where a patient with dementia leaves the ward without formal or self-discharge and without staff knowledge [31,32]. These events are typically accompanied by litigation, with NHS trusts found liable for negligence and paying substantial compensation to affected patients and/or their families.

Policy responses have proliferated, generating a complex web of guidelines and protocols focused on risk assessment and strategies to prevent injuries [28,32,33]. At the ward level, institutional protocols require staff to maintain heightened vigilance and implement specialised interventions to manage and reduce perceived risks during hospital admissions [32–34]. Overall, managing falls and reducing risk is part of an imaginary of health care delivery in which patients are compliant and contained, either in bed or seated at the bedside [5,11]. Staff are thereby able to maintain routine and timetabled care without perceived unnecessary interruptions [20,35].

This paper will argue that patient risk has been transformed into a tool for protecting workload, produced by institutional cultures of containment. In the case of PLWD, restrictive practices are the institutional tool that supports this shift. Restrictive practices facilitate the rearticulation of the sociotechnical imaginary of a safe and orderly ward, with health and safety regimes reinforcing commitment to that order, as Jasanoff and Kim [27] (p. 26) describe it, 'coherence and continuity.' This imaginary becomes most visible when institutions face events or individuals that unsettle that order, prompting the activation of

measures, policies, guidelines, and practices aimed at restoring the desired vision of safety [27].

3. The Production of Dementia as a Risk Classification

Increasing numbers of PLWD admitted to acute hospital settings accentuate the challenges these wards face [9], as they are neither equipped nor designed to care for PLWD. We have reported elsewhere [5,36] that PLWD tend to challenge staff imaginaries of what constitutes a 'good patient,' one who is sedentary, bedbound, compliant, and who presents minimal health and safety risks to the ward and others. However, for PLWD, longer admissions due to delayed discharges are associated with progressive frailty and functional decline, which in turn exacerbate cognitive deterioration, frailty, and dependence on ward staff [37]. For PLWD, hospital settings are unfamiliar environments with routines and processes that can be confusing [11], increasing fall risk. The risks are further compounded by environmental factors such as lighting, flooring, and spatial unfamiliarity, as well as the fast-paced nature of care delivery, which intensifies disorientation and the cognitive and sensory burden [38,39].

In response, institutional processes prioritise falls risk assessment [7,40], focusing on identifying risk factors and associated increased risk of falls [33,34,37,41]. For institutions, the urgency to reduce falls and respond quickly derives from concerns about potential harms, falls-related mortality, and litigation [42]. For staff, this is compounded by fear of blame, as inquiries into these incidents tend to eventually cascade down to individuals on duty. This persists today, brought into sharp relief by increasing patient cohorts living with dementia [1,43]. Decisions about how care should be delivered to PLWD with complex medical needs are often framed with projections of their competency and ability, resulting in care practices that restrict their personhood, freedom, and dignity [5,44].

In the care of PLWD, concerns extend beyond a simple safety-first ethos. When admitted to these settings, PLWD and the assumptions around them create resource challenges. Often under-resourced, ward staff strive to maintain order and operational flow while managing and mitigating anticipated health and safety risks. PLWD become 'disruptive subjects' because their behaviours violate the imaginary order of the ward. In response, staff employ every available tool, including restrictive practices. Incidents are logged and monitored. In some cases, updated boards resembling the accident-report boards used in industry settings publicly display the number of days since the last adverse event, such as the one shown resetting at the Springfield Nuclear Plant at the beginning of each episode of *The Simpsons*. Prolonged periods without falls become markers of good team performance, a practice adopted from industry. This exemplifies how staff use restrictive practices, monitoring interventions, and surveillance of ward incidents not simply for risk management, but to perform an imagined safe ward, reframing restrictive practice as the symbolic labour that sustains institutional visions.

While the existing literature has established risks to people living with dementia during a hospital admission and methods taken to mitigate them, there is little to no evidence of how this equates to everyday practice and its impacts on people living with dementia. This paper draws on findings from original research into how restrictive practice is applied to people living with dementia [2], which provides a unique empirical foundation for how matrices of safety and risk contribute to cultures of containment and restraint, and the impacts this has on the experiences of people living with dementia and the staff caring for them. We used this evidence to argue that imaginaries of safety and risk lead to anticipatory practices that can create new harms and suggest a need for a reorientation of risk management in institutional approaches and responses to people living with dementia during a hospital admission

4. Methods

4.1. Data Collection

The research team employed an ethnographic approach to data collection. Ethnography involves the in-depth study of actions and accounts of actors and agency within everyday settings [45]. This approach enables researchers to examine topics where measurement is neither easy nor appropriate, or where practices are tacitly understood [46,47]. It provides nuanced tools for understanding complex social relations and cultures within healthcare settings [48]. Ethnography is simultaneously unstructured yet sophisticated, offering insights into the complexities of everyday organisational life [45,49]. In healthcare settings, this approach allows the researcher to examine individuals, groups, disciplines, and teams under the umbrella of care [50], as well as those affected by it, collecting experiences of patients, care partners, and advocates [51] and the interplay among them [52].

For this study, data were collected (observation and in situ interviews) across six acute wards in three hospitals in England, along with three specialist mental health units in a neighbouring NHS Trust. We employed purposive and maximum variation sampling to include hospitals covering a range of geographical locations, demographic catchments, expertise, and interventions. All hospitals were purposefully sampled so as to represent an average hospital. None of the sites visited were under special measures or had negative assessments from the Care Quality Commission, nor were they seen as exemplars of care, or running their own initiatives in relation to improving care of older patients.

Acute wards were purposefully sampled for their high likelihood of admitting PLWD for a non-dementia condition, such as Medical Assessment Units and Older People's Care Wards. These settings are where PLWD are likely to be admitted for short-term, unscheduled treatment within the acute hospital. Mental Health settings were units specialising in older people's care known to have a high prevalence of dementia-related admissions. The hospital sites all served diverse populations; however, this was not always reflected in their inpatient population

4.2. Study Design

Data collection took place between January 2023 and August 2024. Within each acute ward, (n = 30) days/shifts of observation were conducted (n = 180 days total). This was accompanied by (n = 15) days of observation within one allied dementia specialist mental health in-patient ward affiliated with the acute wards (n = 45 days total). A total of (n = 225) days/shifts of ethnographic fieldwork was conducted within these sites.

Observations were conducted by the authors. Observations ranged from two to six hours and were reactive to events within the wards during these periods. Observations took place in many 'public' areas of the wards, such as ward corridors, nursing stations, and clerks' desks. The researchers never went behind screens or observed intimate care. The researchers observed patients only at the bedside or in single-occupancy rooms, with written informed consent.

Data collection was recorded as field notes. The researcher was embedded within the ward, taking field notes for a duration in the range of (n = 2–5) hours a day. Observations were accompanied by short in situ interviews, lasting in the range of (n = 1–5) minutes and recorded as field notes as part of observations. These brief conversations (n = 1168) with ward staff sought to rationalise everyday practice and decision-making as it happened. A total of (n = 1048) in situ interviews were taken across acute settings, including (n = 85) with doctors, (=72) with senior nurses, (n = 319) with nurses, (n = 283) with care assistants, (n = 169) with other ward staff including clerks and porters, and (n = 120) with PLWD admitted to the ward. These interviews with PLWD explored the experiences and impacts of these same practices and decisions. In mental health settings (n = 68), interviews

took place, including (n = 23) with senior nurses, (n = 30) with nurses, (n = 12) with care assistants, and (n = 3) with other ward staff. PLWD were not recruited in these settings due to their capacity to provide informed consent.

In total, (n = 168) participants provided informed consent across all settings for observations and in situ interviews. Inclusion criteria for participation included any individual working on the ward, PLWD admitted to the wards and judged by medical staff to have capacity, and carers of PLWD. Patients without dementia, or staff caring for patients in an area of the ward without admitted PLWD, were not observed or recorded.

Fieldnotes of observations and in situ conversations were written up near verbatim into Word files [53,54]. Approximately 500,000 words of observational fieldnotes were collected, written up, transcribed, cleaned, and anonymised by the researchers.

4.3. Data Analysis

We applied an abductive approach to ongoing analysis, developing our hypothesis from the data as they were collected rather than a priori. Ethnographic abduction [55,56] supported the aim of understanding rather than minimising the complexity of everyday life within these ward settings. The constant comparative method was employed alongside theoretical sampling, allowing us to intertwine concurrent data collection and analysis [57,58].

Field notes of observation, experience, and in situ conversations were written up near verbatim into Word files. Qualitative Analysis Software (NVivo) was used for both analysis and to ensure password-protected encryption of data to assist the secure management of anonymous data, facilitating team access.

Analysis involved developing and testing analytic concepts and categories, and strategies for their development, including careful reading of the data, looking for patterns and relationships, and noting anything surprising, inconsistencies, and contradictions across the range of perspectives gathered. Initially, this produced a collection of concepts and analytic memos, which informed the development of more refined and stable analytic concepts. Line-by-line coding is not appropriate for fieldnotes, where coding is selective and involves whole events or scenarios. Rather, the constant comparative method allowed the coding of data into categories via a recurrent process. The analytic concepts that emerged from this process were tested by the authors and the wider research team. Codes were refined to develop stable concepts transcending local contexts to identify the broader structural conditions outlined in our findings. The findings presented in this paper represent a subset of these original data, the full findings of which are reported elsewhere [2].

All sites, individuals, and data collected were anonymised and stored in line with the UK General Data Protection Regulations as part of the Data Protection Act (2018) and the NHS England Data Protection Policy (2014). Storage of the data is managed by the University. This study complied with the Consolidated Criteria for Reporting Qualitative Research (COREQ) reporting checklist, published alongside the full reporting of this study [2].

5. Findings

Our analysis identified several key themes that show how sociotechnical imaginaries of safety and risk shape ward practices and patient experiences. This discussion centres on three interrelated themes: *institutional cultures of risk removal*, *institutional anxiety and cultures of anticipatory control*, and *atrocity stories and the reframing of restrictive practices as safety measures*. We address these in turn, showing how organisational understandings of risk lead to cultures that minimise it, producing imaginaries that affect everyday care and approaches to people contained within them.

5.1. Institutional Cultures of Risk Removal

Across these wards, we identified staff imaginaries of a 'good' ward were consistently linked to expectations of order, quietness, and compliant patient behaviour. These imaginaries were contoured by institutional expectations and reinforced through managerial oversight. We observed ward managers frequently conducted spot checks to ensure adherence to safety protocols, particularly those aimed at fall prevention. These practices reflect a broader institutional imaginary in which safety is equated with control and the quantifiable.

> *The Ward Coordinator wonders what to do with one–to–ones, patient in bed F3 just lying flat at moment but discusses patient in bed S3-if left alone for a minute, she will stand up, though she is very frail and has limited mobility. If the coordinator removes the one-to-one and the patient falls, then its fracture and a long-term stay. She recalls that a few weeks ago they removed the one-to-one from a patient on B bay, and when the nurse went to the storage cupboard opposite the bay door, the patient fell- less than 30 minutes after removing one-to-one. The coordinator got the blame for making the decision. That patient was only 'an 8, so only borderline' [Ratings scale used to assess frailty and support need] and has to balance one-to-one with wider needs for staff across the unit. Typically, each HCA has 12 patients which is a lot, and mostly unsighted because of layout of unit, which is hard to walk around with obstacles and people* (Site F, Day 72)

Managerial oversight and constant reminders to 'attend' linger from classical approaches to nursing and care [59]. The need to remove risks in everyday ward practices meant that all staff were acutely aware of this priority. Across sites, a calm safe ward was a desired goal. The ward's physical layout exacerbated risks and potential disruption to order by limiting visibility and increasing concern about patient movement. As in the example above, these spatial constraints and the perceived risks they represented intensified the perceived need for restrictive practices.

The desire for a quiet, risk-free ward recurred in staff conversations. Quietness was imagined as a marker of a good day, good care, and effective risk management, and disruptions—particularly those associated with PLWD—were seen as threats to this ideal [27]. Across shifts, it was common to hear and observe staff refer to the quiet or lack thereof during shifts. Many pointed to a desire for a time when the ward could be quiet and risk-free so that they could 'get on with things' and focus on what they see as essential work of the ward–completing medical records and administrative tasks. This is where everyday invisible restrictive practice was employed, such as raised bedside bars, allowing administrative tasks to be completed while patients were contained in their beds.

> *Only two patients out of the whole ward are out of beds,– bed15 and bed20- who are sat in bedside chairs. The lady in bed 17 has gone home overnight. The remaining 17 patients are in bed with the side bars raised, despite it being mid-morning. The ward is very quiet, there are no rounds ongoing, just nurses and HCAs. There is a mundanity to the ward itself; it's very quiet, there are no visitors, no shouting, no buzzers and no patient movement. Everyone is in bed or sat at the bedside, inside the locked ward, while work goes on around them [Site B Day 29]*

The use of everyday restrictive practice and technologies, as observed above, was not based on immediate patient behaviour; rather, they are anticipatory, informed by perceived risks and prior incidents, and demonstrate the desire to maintain the collective workflow and order of the ward over engaging and mobilising patients.

Patients who are identified as 'at risk' have more visible restrictions than those patients who could otherwise interrupt the operations of work. They are often assigned one-to-one supervision as a precautionary measure, even when they are not actively exhibiting

behaviour that would warrant such intervention. This heightened surveillance reflects the logics of anticipatory control [60], where staff act to prevent potential incidents before they occur.

> *Screen the ward, early afternoon. Patient in bed 23 has a one-to-one carer sat with him as well as raised bedside bars, also has an IV drip inserted. He has also been fast asleep all afternoon, the one-to-one is dressed in a generic nurse uniform that does not belong to the hospital. Unit feels very orderly. No doctors on rounds but nurses and care staff present on each bay, On the other half of the unit the nurse in charge confirms that patient in bed 29 is the only patient with one-to-one supervision, the male HCA otherwise assigned to the bay, sat in a chair doing admin on a laptop with his back to the patient. The man from bed 29 is mobile, rising up from his chair but unable to move because of the occupied chair in front of him; the HCA focused on the laptop. One-to-one is for fall risk but so far not creating distress, simply a presence or obstruction; no verbal instruction given and no legal frameworks in place. Patient in bed 29 has now stood up; a continence pad is visible through his open robe, and he seems very wobbly on his feet. He stands behind HCA, who blocks him from moving any further* [Site D, Day 42]

Even sleeping patients are monitored closely, with staff maintaining vigilance to prevent falls or 'absconding'

> *Patient in bed I3 is still asleep on bed, a male one-to-one HCA is sat at foot of bed working on a computer, no more shouting now. Whole unit is very calm. Very little to observe. Two one-to-ones, rationale for one is that the patient is a fall risk from bed, for the other is mobility but both patients asleep. Rest of the unit is really quiet.* [Site F Day 76]

Staff often use spatial strategies that varied in nomenclature and implementation from site to site. These included 'bay tagging', 'enhanced care', or 'cohorting', whereby a whole bay or ward area is supervised by a single one-to-one carer, limiting movement and keeping patients within a given space or room. These measures are not always overtly restrictive but serve to maintain visual awareness and physical control over patients.

On the door of bay are two laminated A4 posters. One covers PPE and masks being required but nothing further. The other is a green poster explaining that this is currently an Enhanced Care Bay. The poster states:

1. *Patient must have an enhanced care plan completed.*
2. *During enhanced care, they must keep patient documents up to date and spend some of their time engaged with meaningful activities.*
3. *Must be in eyesight of their allocated person at all times. If the 1:1 is required to go behind a curtain or have their view obstructed, they must first find another member of staff*
4. *The Enhanced care worker must rotate every two to four hours.* [Site B]

Similar instructions were seen and discussed at other sites, including the need to pass a physical card showing who had personal responsibility for the restricted area at any given time. Despite the instructions at each site for meaningful activities or to encourage patient movement, these were rarely implemented. Enhanced care was often outsourced to security, delegated to somebody completing paperwork nearby, or the assigned person to a junior member of care staff, left to sit beside a door or bay. It was not unusual for a single staff member to cover a whole shift outside of breaks and rounds, with most wards having a care assistant unofficially designated as the enhanced carer.

5.2. Institutional Anxiety and Cultures of Anticipatory Control

Institutional anxieties about health and safety breaches are palpable in the everyday clinical practice we observed across wards and settings. Decisions are influenced by fear of blame, previous incidents, and the pressure to meet institutional metrics. These pressures lead staff to use a narrow range of ward tools, physical, pharmacological, and

procedural to maintain control and prevent incidents, even when such measures conflict with the needs of the person in their care in that moment:

> *Rationale of fall risk and absconding clear. HCA on F closes door to bay for quiet, blinds on windows are drawn. Bay is dark and quiet- artificial night time. Patient in bed F is not asleep, moves and looks around, but HCA clearly trying to encourage her to sleep. Lots of nurses gathered talking by station, senior sisters talking in day room, all have jobs/notes but calm, convivial* (Site F day 75)

We observed that patients who attempt to move independently are often redirected or physically restrained, especially when staff perceive a risk of injury or disruption to the desired order of the ward timetable.

> *Male HCA telling the female HCA about to start her shift to call security if the man living with dementia from bed 21 goes to main door as he is strong enough to force door and to hurt them. 'You are half the size of me'—he gives her a fob with security alarm on it and explain how it works, it is a panic button. He then checks everybody on shift knows the phone number for security number 21 is described as someone who does not punch but is 'pushy' and can sound more aggressive than he is. He has previously been administered with Lorazepam but today has been allowed to walk around one bay. Nurses instructed to respond to any alarm immediately* [Site D, Day 55]

Of interest here is how staff anxiety and escalation of use of restrictive practice leads to increased distress among patients, but this is seen as a feature of their dementia, rather than a response to practice. In cases where patients are perceived as highly disruptive or aggressive, sedation is used as a last resort to restore calm and reduce perceived risk. This is often framed as necessary for patients and staff safety but also reflects institutional pressures to maintain order. In the example above, the patient was twice administered sedatives overnight following the shift handover.

Everyday organisational approaches to managing and ensuring predictability can bring about anxiety among staff and their use of restrictive practices in everyday care. These practices reflect a ward culture of anxiety in which risk is imagined as ever-present and must be pre-emptively managed. The material environment—darkened bays, closed doors, and quiet corridors—becomes a stage for performing safety, often at the expense of patient autonomy.

Cultures of Anticipatory Control

In response to institutional anxiety about health and safety, restrictive practices serve a dual function: they fulfil institutional protocols and provide staff a sense of protection against blame. Staff are acutely aware of the consequences of incidents occurring under their watch, including paperwork, investigations, and potential litigation. This fear drives a culture of hyper-vigilance and risk aversion in which taking anticipatory actions [61] to avert risks becomes part of everyday clinical practice. This is illustrated in the field notes below:

> *'Researcher: what impact do you think locked doors have on patients though?*
> *Registered Nurse: I know most of them want to go home; they feel contained and held against their will. It does cause a lot of distress, because they are unfamiliar with the surroundings, especially those with dementia. They are disoriented and confused about everything. For us though, its gives us peace of mind– they are in here and safe. So, we don't have to worry about them that much. We also have a bay tag system. Patients only leave the bay if they need something else; otherwise, toilets are within reach and staff on hand to help. But all the paperwork we have to complete if an incident happens–it's a lot of work. I would leave late you know. [Site F Day 21]*

The participant explicitly points to institutional anxiety and the implications for clinical care team failure of the clinical care team to follow and/or use restrictions practice. These include the much-maligned paperwork, additional workload, and potential investigations that could lead to litigation and blame if a patient comes to harm under their watch. However, this fear also contributes to underreporting or avoiding acknowledgement of harm caused by restrictive practices.

> *Registered Nurse: "So I've been thinking about your question the other day about restrictive practice and the ward. So, patient in bed A2–she has big black eyes and huge bruise on the nose. We are at a loss to explain what happened to her. There is no record... …but you can see why I prefer to have one-to-one and patients' bay tagged all the time. So, When we talk about restrictive practice bro that's what I mean. That is why we need it on the ward. Patient A2 had a fall now has black eye. It's like she was in a boxing ring. But no one knows how she got hurt. No report no one and no one knows how it happened–nothing" [Site F Day 87]*

Because of incidents like those described above, restrictive practices were frequently used as anticipatory interventions [61,62], based on staff expectations of risk rather than immediate patient behaviour. Staff described balancing the need for one-to-one supervision with broader staffing constraints, often under pressure from previous incidents and fear of blame. The use of restrictive practices for PLWD must therefore be seen also as a means of responding to expectations of implementation of protocols to ensure safety and order on the ward by managing and mitigating anticipated risks based on prior experiences.

> *Dementia care team arrive just after lunch. They are here to assess patient in bed J2, but she is now fast asleep after being sedated with Lorazepam following multiple attempts to leave her bay. The team speak to me quickly and are both shocked that the patients 2 sedated given how settled she had been the previous day. They both go and speak to the HCA about what is happening; their team didn't know why the patient has been from bay G where she was settled to the more isolated J bay, and again mention how happy she was yesterday. Five minutes later the dementia team talks to nurse, discussing the patients pain medication. The nurse says she has refused all medication today. The dementia team mention the change in behaviour, ask if they tried alternatives like subdermal medication before sedating.* [Site F, Day 62]

These decisions were shaped by both institutional protocols and personal experiences, revealing how sociotechnical imaginaries (Jasanoff and Kim 2015) of safety are enacted in everyday ward practices.

5.3. Atrocity Stories and the Reframing of Restrictive Practices as Safety Measures

Staff accounts of taking '*preventative measures*' reflect the anxiety about risk removal outlined earlier in this paper. They also illustrate how ward teams use what we refer to as atrocity stories as the starting points to see restrictive practices that facilitate the performance of the health-and-safety imaginary.

Staff anxiety often became apparent not only in fear of what a patient may do to them or another patient, but also to themselves. Extreme events, such as a patient leaving the ward and walking straight out of the hospital, were a common example, alongside stories of being attacked or of patients trying to smash windows or equipment. Often, these stories stood in stark contrast to the abilities of an acutely older person who was also simultaneously classified as being a fall risk, although instances of violence against staff and carers were observed at points throughout our study and must not be dismissed.

> *The ward coordinator has a real fear of patients absconding, while at the same time pointing out how many are simply too ill to move around. She is discussing how the fire doors at one end of the unit lead straight out on to the main road and busy traffic, and that the main*

exit of the unit also leads outside. They asked last year for a sensor alarm for the rear fire door but were told there were no funds for it. She tells me when patients can move it can be tricky, last week one man on Bay A got off the unit twice and tried more, distracting staff by requesting a cup of tea then dashing when they went to get one for him [Site F day 88]

Stories, anecdotes, and or moral tales of 'atrocity' refers to common staff accounts or stories of PLWD who had, or potentially had, 'absconded' or 'escaped' and were found in various locations miles away from the ward, or accounts of near misses, patients who had terrible 'falls' or were in traffic accidents outside the hospital. These stories were transferable and heard in slightly different versions across staff, wards, and sites.

> *The pharmacist comes to the nurse's station to ask about a patient who is due to be discharged about take-home meditation. She is ushered through a door behind the station. I comment I did not realise there was a door behind the workstation and tight security including locks around the ward. Clerk and a healthcare assistant tell me of the fire exits and doors mechanism used in the ward. "We used to have a green button to press on exiting the ward. The current measures require swiping in and out and similarly, fire doors require operating. These changes followed a patient who let himself out– absconded– from the ward for over six hours. In that time, he visited a pub, got some free drinks, and was injured and taken to a hospital in the nearby town who called the hospital to ask if we were missing a patient. Since then, ward's main door uses a swipe card for entering and exiting. Fire doors now only open in the event of an emergency."* [Site D, Day 35]

These accounts highlight the impacts on the patient and the ward team when PLWD are allowed liberty to move. While versions of these scenarios do occur, they feature heavily in staff accounts used to justify restrictive practices. Notably, such events were never observed during our fieldwork; rather, they are reported to have occurred prior to our visits or after we had left the ward. Rarely did we witness them first hand, yet staff repeatedly invoked these stories to rationalise their actions:

> *The Ward has been told they can no longer use the hospital's specialist enhanced-care support; they must manage within their own teams today. The HCA's and nurses 'bay tag' all patients that require one-to-one observation and work to ensure continuous supervision as they go about their roles. The nurse in charge explains this will be a "challenge" for the "team": "we have to be ever so careful with the patients who wander around the ward, who are at risk of falls….you won't believe this, it has happened a few times. Some of the patients look so cognitively able, one followed a visitor, out while chatting but then got confused in the lift. Another one was found on the ground floor by a member of staff who had gone on her break. It was a relief someone found her because if she had gone out on the street, I don't want to think what that would have been like for us." [Site F Day 81]*

It was therefore common for staff to reframe restrictive practices not as restrictive interventions but rather as safety measures aimed at managing perceived risks—to the person and to themselves in the event of a significant adverse incident. The measures were often taken in response to institutional challenges, in particular staff shortages.

> *Nurse in charge: "We are short-staffed. No one is on Dols but for the patient in bed 2, though I suspect they expired. Bed 2 is also one-to-one; nobody else is. Patient in bed 5 is still on the ward. only concern is possibility of escape. She likes to Wander a lot and is very convincing with ward visitors….it does happen and it can be a big issue if she did for me. I remember one who escaped into the city a while back. I know we have CCTV but also that she can go round the ward since the corridor is circular which is good but if She escapes it is a different matter altogether".*

[move discussion to patient in a side room]

"He is still the same. Still on Lorazepam PRN. He has kicked out a number of times but okay. The rest of the patients–it's still bay-tagging. It means staff have to keep an eye on all patients. But I have also assigned an HCA so Staff can attend to him. it's not officially one-to-one supervision; it's more of a preventative measure. I do it for my peace of mind. I don't want to be recording incidents on my shift. [Site F Day 67]

Renaming restrictive practice as essential safety measures is not merely semantic: these are material interventions with consequences for PLWD. What may appear to ward staff teams to be inconsequential, 'harmless' forms of containment are routinely used and embedded in everyday care, often without being considered or recorded as restrictive practices. Raised bedside bars, strategic placement of furniture, verbal commands, and closed doors were habitually employed under the banner of safety.

6. Discussion

Our analysis shows how sociotechnical imaginaries of safety are not abstract ideals but are materially enacted through ward routines, spatial arrangements, and staff behaviours. The ward itself becomes a medium through which these imaginaries are channelled and sustained. Restrictive practices are not merely clinical tools but performative acts that stabilise the ward's imagined order. These imaginaries endure because they provide staff a framework for managing uncertainty and complexity, even as they conflict with PLWD's lived experiences, care needs, and rights.

The findings in this paper illustrate how sociotechnical imaginaries of health, safety, and risk management [24,27] are deeply embedded in the institutional and everyday practices of acute hospital wards. Shaped by historical developments in occupational health and safety policy, these imaginaries have evolved to prioritise risk minimisation, routinisation, and institutional order over individualised, relational care. Within this framework, people living with dementia (PLWD) are frequently perceived as disruptive to the smooth functioning of the ward, particularly when their behaviours [19,20] challenge normative expectations of compliant, sedentary patients.

First, we show how restrictive practices emerge as institutional responses to these perceived disruptions. Under pressure to maintain safety metrics, especially fall prevention, staff implement interventions that prioritise control and containment. These practices are not merely clinical decisions but performative enactments of broader imaginaries of what constitutes a safe and well-managed ward. Safety is imagined not as relational or person-centred, but as the absence of risk, movement, and unpredictability. Restrictive interventions thus materialise the sociotechnical imaginary of order.

Second, our ethnographic data illustrate how these imaginaries are both reinforced and resisted in practice. Staff often express ambivalence about restrictive interventions, recognising their potential to cause distress and exacerbate confusion among PLWD. Yet, the institutional logic of safety, coupled with fears of litigation and professional accountability, compels their continued use. This tension reflects a misalignment between PLWD's lived realities and the institutional imaginaries that govern their care.

Moreover, the sociotechnical imaginary of the 'safe hospital' extends beyond policy into the spatial and temporal organisation of care. Ward layouts, lighting, routines, and staffing patterns are configured to support a vision of order and predictability. PLWD, whose needs often fall outside these configurations, are rendered as risks to be managed rather than individuals to be supported. This underlines a cycle in which restrictive practices become both a symptom and a solution to institutional challenges.

6.1. Dementia as a Risk Classification

Building on these insights, we argue that dementia functions within acute hospital wards not simply as a clinical diagnosis but as a risk classification. In this framing, PLWD become risk-classified subjects through institutional imaginaries of disruption rather than through their clinical needs. Dementia becomes a sociotechnical category that signals anticipated unpredictability, movement, and deviation from routine, qualities that violate the imaginary of a safe, orderly ward.

Behaviours associated with dementia such as wandering, agitation, and resistance to care are interpreted less as expressions of distress or unmet need, and more as violations of the expected patient role. Staff respond not only to what PLWD do but to what they might do. This anticipatory orientation transforms dementia into a marker of institutional risk, justifying heightened surveillance, containment, and pre-emptive intervention.

Safety metrics and accountability structures amplify this dynamic. Fall prevention regimes, fear of litigation, and professional anxieties compel staff to demonstrate proactive risk management. Dementia thus becomes a category that legitimises restrictive practices as necessary safety measures. These interventions, in turn, reinforce the classification: PLWD are seen as risky because they are subjected to restrictive practices, and restrictive practices are deployed because PLWD are seen as risky.

This feedback loop has moral and affective consequences. Staff often recognise the harms of restrictive interventions yet feel compelled by institutional logics to act pre-emptively. Extreme but rare atrocity narratives circulate within staff teams, functioning as moral anchors that justify restrictive practices and intensify anticipatory action [61,62]. PLWD who resist these interventions are further classified as disruptive, prompting even more restrictive responses. These dynamics shape care trajectories beyond the ward, contributing to delayed discharge and increased institutionalisation [2,5].

6.2. Extending Sociotechnical Imaginaries to Micro- and Meso-Care Settings

This paper extends the application of sociotechnical imaginaries as a sociological concept to the micro and meso levels of acute hospital care [27,63,64]. We illustrate how national imaginaries of a safe industrial Britain permeate health and social care spaces, entangling with existing policies and practices to create a milieu in which risk reduction and institutional priorities take precedence over the needs and experiences of PLWD. Sociotechnical imaginaries of health and safety gradually permeate hospital environments, shaping ward routines, materialities, and care practices.

We emphasise the importance of sociotechnical imaginaries by showing how collectively held visions of safe, risk-free hospital wards are sought and performed through policy, guidelines, and everyday practice. Imaginaries of health and safety, and associated temporalities of urgency and accountability, shape the material and organisational infrastructures of care. Restrictive practices thus become performances of desired visions of order enacted by staff teams striving to achieve these imaginaries.

7. Limitations

The potential for the Hawthorne effect was considered within the study design, with the duration of the observation period within each ward designed to minimise this. Researcher interpretation is acknowledged within ethnographic research, with a three-person team and extended periods of data collection designed to mitigate this. The data collected cover only acute hospital and specialist older people mental health settings and therefore the findings may not be transferable to other health care environments.

Post-admission follow-up interviews with people living with dementia and their family partners were not possible due to the low number of family visitors across all ward settings during the observation period.

8. Conclusion

Understanding restrictive practice as the performance of sociotechnical imaginaries, and dementia as a risk classification, offers a new conceptual pathway for analysing institutional responses to dementia in acute hospital settings. It reveals how PLWD become positioned within systems that prioritise risk minimisation over relational care, and how institutional anxieties drive anticipatory practices that intensify restrictive interventions.

Staff working within clinical settings that care for PLWD must address the organisational conditions that sustain restrictive practice, rather than looking at individual staff conduct or singular events. Training in de-escalation and positive risk-taking is proposed to address the inadequacy and helplessness staff reported, potentially delivered through mental health nurse secondments. The study also calls for greater organisational flexibility and a slower pace in timetabled bedside care, for better use of existing ward resources, and a move beyond metrics for adverse events such as falls as a measure of local care quality and liability.

Future research should examine the long-term impacts of restrictive practice on PLWD beyond hospital discharge, including effects on wellbeing, autonomy, and care trajectories. More broadly, reimagining safety in acute hospital wards requires challenging dominant risk-averse logics and developing alternative imaginaries that centre complexity, relationality, and the lived realities of PLWD.

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