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ORIGINAL ARTICLE

Ontological insecurity of inattentiveness: Conceptualizing how risk management practices impact on patient recovery when admitted to an acute psychiatric hospital

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Abstract

Risk management which assesses and mitigates risks such as suicide and violence is under scrutiny, particularly within psychiatric inpatient settings. Restrictive practices, which result from risk assessment, such as observations, physical restraint and ward seclusion can impact negatively on patient recovery, hindering abilities to develop a meaningful life that emphasizes purpose, hope and autonomy, despite experiencing mental distress. Yet, less is known about the impact from the patient's perspective when first admitted to hospital, a period which among other reasons may come with increasing risk management practices owing to the clinical uncertainties about patient risks. In this grounded theory study, we explore the impact on recovery, interviewing 15 adult participants with patient experiences of being in an acute hospital. The main theme of the study, termed a core category with a grounded theory, was identified as "ontological insecurity of inattentiveness". This highlighted a staff inattentiveness with involving patients with risk management and explaining the purposes of the practice, which raised insecurities about what was happening to the patients when admitted to hospital. Four subcategories support the core category; discounting the patients' experiences to gain a meaningful grasp of risk management, ambiguity about risk management rules, particularly the reasons around their use, forebodingness to the hospital environment and, management from afar, with patients feeling scrutinized from observations without a voice to offer different views. It is hoped these findings will add to the field of patient involvement in psychiatric inpatient settings, proposing attempts to raise understanding and inclusivity of risk management, starting when first admitted to hospital.

KEYWORDS

acute psychiatric hospital, grounded theory, ontological insecurity, patient perspectives, recovery, risk management

INTRODUCTION

Risk management and recovery are clinical practices that can be in direct conflict with each other. Recovery aligns with enriching a meaningful life despite mental illness, building a sense of hope and purpose in life alongside autonomy over care decisions. However, risk management adopted to mitigate risks such as suicide and violence in acute psychiatric hospitals may impede recovery via restrictive practices, notably disempowering the patient via little involvement with risk assessments and loss of dignity by use of physical restraint and forced medication (Felton et al., 2018). Perkins and Repper (2016) argued that recovery principles are a vital vehicle for risk management to be more inclusive of patient needs and address restrictive practices. Yet to date, little data exists from patient perspectives about their recovery in the context of risk management within

an acute inpatient setting. Hence, the study explored these perspectives to better understand how risk management may impact patient recovery situated around one acute hospital in the United Kingdom (UK).

BACKGROUND

Recovery is built on the principle that mental health care may enrich a meaningful life despite experiencing mental illness, rather than be characterized as a cure (Anthony, 1993). While recovery can come with diverse meanings in terms of individuals developing a fulfilling life, research has identified some common themes such as building hope for the future and participating in decision-making while seen as an equal with clinicians in how to attain personal needs (Winsper et al., 2020). Recovery-orientated care in hospitals acknowledges that mental distress interrupts the person's life, but is not defined by it. To meaningfully address this disruption, it is important to involve patients, so they feel that they have a voice (Davidson et al., 2006). For example, informing the person about the purposes of the hospital and including patient views within their care, can contribute to experiencing stability and safety when first admitted to hospital (Muskett, 2014). Discussions about the purpose and expectations of the admission can help patients to acclimatize to what can be alien and frightening environments, in part owing to mental distress, and level of ward disruption (Pelto-Piri et al., 2019). Hence, when possible, clinical approaches in hospital should be meaningful to patients, requiring care to be shaped around patient beliefs in what may improve their lives (Deering et al., 2019).

UK Department of Health (2009) guidance suggests recovery forms part of risk management; a practice that assesses and mitigates risks to self and others that negatively impact the patient's life, and those around the person. Risk management commences with assessments to identify risks and ways to promote safety, thus informing diverse decisions that create management strategies, ideally with the patient views at the heart of these plans. While risks can be wide-ranging, including iatrogenic risks, such as minimizing the use of medication with extensive side effects to promote patient safety, the tendency is to address deliberate harms in line with clinical views, involving patient self-harm, suicide and violence (Bennison & Talbot, 2017). Nevertheless, risk management should help the patient feel understood regarding their safety, and empower them to be in control, allowing for therapeutic risk-taking, whereby calculated risks are taken with the patient to engage in activities that may improve quality of life, such as gaining friendships and employment (Felton et al., 2017).

There needs to be risk management in therapeutic health care, such as addressing iatrogenic risks, however, risk management in psychiatric hospitals can be criticized for the deleterious impact on recovery (Perkins & Repper, 2016). Concerns involve patients not having a voice in shaping risk management practices, while interventions can impede a quality of life via physical restraint and ward seclusion (Slemon et al., 2017). Mental illness can be viewed as making people unable to acknowledge risks, subsequently meaning that patients have little participation in risk assessments (Harbin, 2014). An assumed intolerance to discuss risks is also suggested, attributed to the disorientation of mental illness, raising clinical apprehensions about increasing deliberate harm and hampering therapeutic relationships if patients are involved (Coffey et al., 2017). Accordingly, tension can exist amid the clinical need to restrict the patient with lessening harm, and the participation needed for recovery (Muir-Cochrane et al., 2011). Given conflicts about recovery appear prevalent yet underexplored within hospitals, this study investigated the patient perspective of risk management and recovery within an acute psychiatric hospital, to generate a starting point for future research and inpatient care.

AIM

Despite risk management seemingly inhibiting patients' abilities to engage in their recovery, patient perspectives about risk management and how its practices impact recovery, appear underexplored in psychiatric hospitals. Hence, the study aimed to develop a grasp of the impact on recovery of risk management, with participants reflecting on past experiences when first admitted to an acute hospital, a period seen to markedly impact their recovery.

METHODS

The impact of risk management according to patient perspectives can be grasped via a social context, involving degrees of social processes with clinical staff and other patients in a hospital setting (Markham, 2020). Constructivist grounded theory (CGT) was selected as the methodology because its stated aim is to investigate the social processes within social situations (Charmaz, 2020), which fits with this study. Given the lack of risk management studies from patient perspectives, the methodology was also selected to generate a theory drawing on these views to inform future mental health care. Through using CGT, the study was able to conceptualize an explicatory system of interlinking concepts in the form of subcategories, scaffolded around an explanatory core category to theorize how risk management might affect patient recovery (Charmaz, 2014).

Participants

Since recovery can involve a life-long journey, in which understanding about attaining personal needs may grow over time (Griffiths & Ryan, 2008), two sampling strategies were devised. Recruitment consisted of adult patients

from a community mental health team recently discharged from an acute psychiatric hospital or, discharged entirely from statutory services, and part of a community support group with experiences of the hospital. Thus, the sampling strategy aimed to capture recent experiences of risk management, but also its impact on those with a possible cultivated sense of recovery. Potential participants were made aware of the study by either the group lead or their aligned clinician. The approach was to ensure recruitment was of people well enough to participate, while via trusted relationships with the assigned clinician or group lead could share their level of interest more freely, about participating in the study (see table 1).

Interviews

A public and patient advisory group reviewed the initial interview schedule for the ethical review process. The review acknowledged that the methodology allowed for questions to evolve contingent on the data analysis, with this procedure outlined below. Through questions such as "What is recovery for you in hospital?" alongside "What is risk management and if it influenced recovery?" participants reflected on hospital experiences, focusing on when first admitted, as seen as a period when recovery was particularly affected. Among reasons, this may be due to the escalation of risk management, in part, a way for clinicians to navigate the risk uncertainties of patients coming into hospital (Dixon & Oyebode, 2007). Participants could elaborate on a personal sense of recovery, the possibilities of such recovery in hospital, and the impact on their recovery from risk management. In total, 15 face-to-face interviews were digitally recorded and then transcribed verbatim, ranging from 40 to 142.55 minutes in duration. Theoretical sufficiency was achieved following the fifteenth interview, denoting a point that the conceptualization held sufficient depth about the impact on recovery, thereby being able to explain the social processes of the theory (Birks & Mills, 2023).

TABLE 1 Demographic data of the 15 participants with patient experiences.

Participant demographics ($n=15$)	Participant numbers
Self-identified sex	
Male	10
Female	5
Self-identified age-range	
20s	7
30s	3
50s	3
60s	2
Self-identified ethnicity	
Black British/African	1
White British	13
White Scottish	1
Self-identified mental health condition	
Bipolar	1
Depression	1
Post-traumatic stress disorder	1
Personality disorder	1
Psychosis	11
Disagreed with schizophrenia diagnosis	1

Data analysis

CGT findings evolve through the constant comparison of data collection and data analysis (Charmaz, 2014). Theoretical sampling was adopted whereby each interview transcript was analysed before the following interview. Analysing the previous transcript aids theoretical understanding of the evolving theory, informing which questions to ask next and which participants might be best to answer these questions (Charmaz, 2017). The iterative way in which the questions were developed contributed to the theory being built from the ground up, embedded within first-hand experiences of risk management. The method resulted in recruiting the group lead owing to rich inpatient experiences and peer-supporting patients in hospital, while also developing into a co-researcher given this expertise, particularly with assessing the authenticity of findings.

Words and sentences in transcripts were abstracted into initial codes relevant to the study aim, with similar codes categorized, then assigned a relevant label termed a focused code (see Table 2) (Charmaz, 2014). After coding a transcript, diagramming sketched out pathways around how focused codes from the transcripts might interlink, alongside building upon the findings from previous diagrams (Chun Tie et al., 2019). This contributed to integrating or removing focused codes, which were gradually refined into the theory's subcategories.

The method of storylining also aided the analysis, building a narrative to help explain the theory's social processes. The narrative was constructed by writing memos throughout the study, a process to not only reflect on personal biases but also generate an audit trail theorizing the interlinking of focused codes, with most memos developing into the basis of the narrative (Birks et al., 2009). To enrich the utility of findings, the final two participants were asked if the evolving theory resonated with their views and hospital experiences. By doing so developed a better understanding of the core category of the conceptualization.

Theoretical coding and core category

Theoretical coding involved drawing on relevant literature to identify relationships amid the focused codes and generate a theoretical framework, to help explain the investigated phenomenon with an overview presented

TABLE 2 Example of coding from interview transcripts.

Interview	Transcript text in the results	Initial code	Focused code	Category in the results
Participant: 1	"A risk […] in the sense that they might find you very odd […] Because you are under scrutiny, you know if you do not behave yourself"	Feeling disconnected	Unaccustomedness	Core category: Ontological Insecurity of Inattentiveness
Participant: 8	"The reality of hospital world is different from patients' reality. We have these two realities competing so need to understand them, explored by all sides"	Competing realities		
Participant: 10	"No comfort in knowing [in what is happening] as everything is so alien"	Getting lost in the opacity		
Participant: 12	"More about keeping in touch with your identity as who you are. This is who I am, this is what I do, it feels suppressed in the hospital. If you do not know where you are going, you are lost"	Discounting identity		
Participant: 5	"Start recovery by myself, think positive stop negative thinking […] try and […] watch the TV, which was hard […] when I was in that dark place, sitting on your own"	Leaving me to sink or swim	Not aligning to the world, I know	Subcategory 1: Diverging the Inside and Outside World
Participant: 11	"It was a spiritual problem; they have not got the ability to deal with that […] they call it schizophrenic because I said I could hear voices"	Disconnecting from beliefs		
Participant: 15	"Then he did not say, it wasn't explained, but said who he was and just sat, assessing me in some way, but he wasn't engaging"	Needing guidance		

in the following core category (Saldaña, 2016). The researcher wrote memos to reflect on the use of theoretical coding, to ensure the analysis aligned with the focused codes rather than the other way around to lessen preconceptions about the meaning of the data (Giles et al., 2013). Ontological insecurity was identified through theoretical coding, turning into the core category of the theory by how it encapsulated the main theme in what was going on for the participants, in terms of the impact on their recovery. Established by Laing (1990), ontological insecurity signifies insecurity in the self, given apprehensions about what is happening to the person may raise mistrust around abilities with sense-making (Giddens, 1991). As will be shown, this impacted recovery, by staff appearing to be inattentive to the needs of patients with little involvement in their risk management and explaining the purposes of its practices, contributing to an insecurity about the reality happening to the patients when first admitted to hospital (Padgett, 2007) (see figure 1 for a diagram outline of the study).

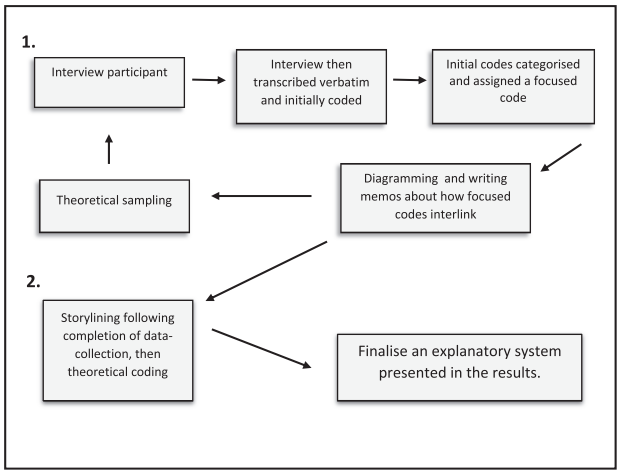

FIGURE 1 Process map of study. Designed by lead author, following the literature of Charmaz (2014).

RESULTS

Interviews were conducted between July 2020 and November 2022 resulting in over 28 h of recorded data with over 4000 initial codes and 60 focused codes in total, alongside 20 diagramming iterations. Results will adopt participant quotes, to support the presented narrative; firstly, with the core category of ontological insecurity, then the four subcategories in how risk management may lead to an inattentiveness to patient sense-making, needed for recovery. The "results" section demonstrates how the subcategories interlink with ontological insecurity, outlined in Figure 2 and the core category below.

Core category

Ontological insecurity refers to a state of deep uncertainty and anxiety about one's place and significance

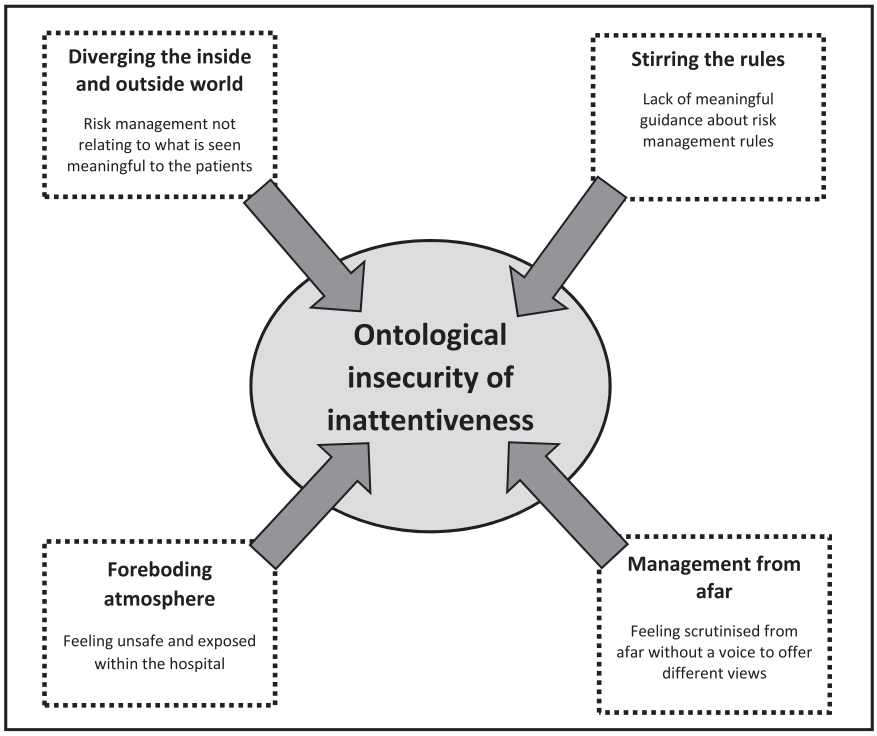

FIGURE 2 Diagram of theory.

in the world and may impact negatively on recovery (Padgett, 2007). In the context of the mental health hospital, the core category identified that ontological insecurity materialized due to the inattentiveness to patient needs surrounding sense-making. Being in a hospital led to a loss of personal identity and autonomy given in part the invasiveness and abstruseness of risk management practices. Participants felt they could be defined by mental illnesses alongside the restrictive practices perceived with risk management, which several viewed as a means to lessen forms of disobedience. This was seemingly with little say, nor apparent explanation, around how the hospital was managed that participants found relatable, contributing to an insecurity in the self.

> The reality of hospital world is different from patients' reality. We have these two realities competing so need to understand them, explored by all sides. (P8)

> No comfort in knowing [in what is happening] as everything is so alien. (P10)

> Patient risks? The individual not conforming to the overall regime. (P11)

> More about keeping in touch with your identity as who you are. This is who I am, this is what I do, it feels suppressed in the hospital. If you don't know where you're going, you're lost. (P12)

Participants also spoke about experiencing disruption to their social roles that provided meaning, adding to a sense of insecurity. A lack of voice in what are risks with little explanations around the deployment of some management practices seemed contributing factors, causing individuals to question their purpose and value as the interventions may obstruct personal growth noted with recovery. It was perceived staff might fear patient reactions to be involved alongside an incapacity to do so due to mental illness. While most shared they were ill when admitted, from the participants' perspectives, illness had not fully impaired their abilities to reason and be involved with decision-making about their care.

> If you see someone getting injected you don't know what is in needle or what they are doing. (P4)

> Scared if don't agree with staff and get aggressive. But […] should be involved in their risk assessment. (P5)

> Moments when I was a bit more lucid, would have appreciated someone say, 'hey you are in a safe place,' if someone said that, would have felt a lot better. (P7)

> You feel they are not taking me for who I am, reducing me to someone who can't do things for themselves, so they are making me feel unwell. (P8)

Participants appeared to speak of stigma influenced by taking on personas of some risk, these ascribed personas appeared to symbolize that they were an oddity to staff, undermining a reality about themselves. Through risk management practices such as observations involving following and watching the patient, paid into seeing risk around some non-conformity rather than enriching safety. The impact of continuous observation was influenced by a lack of explanation about these practices, furthering a sense of insecurity and isolation.

> A risk […] in the sense that they might find you very odd […] Because you are under scrutiny, you know if you don't behave yourself. (P1)

> Somewhat unhelpful, I did feel who is that, why are they watching me …this is weird… without telling me. (P7)

> Like stigmatised, it draws you from society, scarry for don't know what will happen next. (P8)

According to participants, hospitalization also involved relinquishing control over one's daily life, treatment decisions, and routines, leading to a sense of powerlessness and insecurity. It was unclear why certain practices occurred, and how these might aid the patients. Questions about the rules regarding risk management, notably, what influenced the use of restrictions, appeared dismissed by some staff in a belittling manner, with some participants assuming their personal views and queries were of less value when experiencing mental distress.

> I actually asked like, so what's the rules?" And he just goes, "you're just mentally ill mate. (P15)

Participants also shared an uncertainty about their care, such as a powerlessness about their recovery journey, in part because risk management appeared to hinder recovery given the view that patients had little say in how they were treated.

> You have no power over your life. It would help to have knowledge about what's going on [about risk management]. (P12)

> Patients can feel helpless and hopeless in their sense of [staff] authority, it felt a bit, am I really welcome here? (P13)

INATTENTIVE CONDITIONS FOR ONTOLOGICAL INSECURITY

Subcategory 1: Diverging the inside and outside world

Although not fully aware of the procedures of risk assessment, most participants suspected staff assessed their behaviours in some way. A mistrust about staff intentions contributed to ontological insecurity when observing and writing in front of the patient occurred without explanation. Not explaining appeared inconsiderate and baffling when compared to social experiences outside the hospital, as suggested that it was reasonable to expect an explanation about the intervention and seek permission beforehand.

> They had a clipboard with peoples' names, and I always like what are you doing, what are you doing, being here doing this all the time. (P10)

> Then he didn't say, it wasn't explained, but said who he was and just sat, assessing me in some way, but he wasn't engaging. (P15)

While participants agreed that risks such as suicide required mitigation, inconsistency could materialize between the worlds inside and outside of the hospital as to why it should, and what might help. It was proposed personal views could be overlooked, notably, it was suggested that spiritual beliefs risked being attributed to mental illness, despite being established over many years and a significant part of recovery with having a reason to live.

> It was a spiritual problem; they haven't got the ability to deal with that […] they call it schizophrenic because I said I could hear voices. (P11)

Distraction techniques were also assumed by the participants to be part of risk management, again perceived around promoting conformity, specifically to self-manage. To alleviate distressing thoughts, for example about self-harm, staff suggested activities to aid distraction or, do something the patient might enjoy. Although the sentiment was somewhat appreciated, it could be an unusual practice compared to what might help outside the hospital. Particularly, having opportunities for sense-making, requiring conversations about the thoughts and how to lessen their distress. The participants' confusion behind the staff's motivations for distraction techniques heightened mistrust in the self around abilities to address distressing difficulties, whereby the hospital could become perceived as

a place necessary to self-manage, invariably without a grasp of how to do so.

> Start recovery by myself, think positive stop negative thinking […] try and […] watch the TV, which was hard […] when I was in that dark place, sitting on your own. (P05)

> I think if you believe someone to be suicidal, if aware they were having intrusive thoughts, basic things like a talk would be better [than distraction]. (P10)

Subcategory 2: Ambiguity about the rules

Ambiguity about the rules of risk management, why risk management was used and why it can be restrictive, could increase mistrust of staff intentions adding to a sense of insecurity. There were attempts to circumvent this mistrust by being overly compliant with the intent this trust would be reciprocated, by staff bestowing more trust in the person. According to some participants, ambiguity also led to provoking staff to enact risk management practices, in an attempt to better understand its rules, noted with barricading a bedroom and probing the rigorousness of observation procedures.

> I obeyed every single command, I tried to earn their trust, but they were not trusting me. (P1)

> I used to sneak out of the window […] between the times they checked up on you, in between obviously, observations. (P11)

> So, they couldn't push the door in, I want to take the piss at the system. (P12)

> I felt like you had to comply with staff because … you didn't want them to treat you like rubbish. (P14)

Alternatively, participants spoke about patients constructing their own rules to cope, involving sharing experiences, seemingly to sustain some security of the self. By mutual disagreement about what occurred in the hospital, to a degree, past experiences were authenticated by fellow patients, reaffirming some abilities to make sense of the world.

> They would tell me their experiences, and it was nice to hear that people had similar experiences. (P9)

Subcategory 3: Foreboding atmosphere

Contributing to ontological insecurity were participant reports of a foreboding atmosphere when admitted to hospital. It came with an impalpability; difficult to explain but felt real, in that the hospital atmosphere was somewhat incendiary, suggesting something imminently could endanger the patients.

> Alienated by the atmosphere […] feelings occurring 'oh I don't want to be here' or, 'I don't know if this is good for me, or I am scared. (P13)

An uneasiness existed about personal safety, as staff might be unavailable as they were doing activities that participants believed to be paperwork, while sometimes staff appeared not to intervene.

> It's kind of fight or flight, very frightened […] you see things very differently cos you can't leave. (P2)

> But it's a bit odd […] they'll wait for you to see if you'll kick off, not talk to you, but they would just stand there. (P14)

Forebodingness could stem from a perceived lack of patient interaction with participant reports that staff sat in the communal areas but made little attempts to engage the patients.

> There were quite a few staff that used to sit in the main area, they were just talking with themselves or on their phones and when the alarm goes, they all react. (P12)

Attention seemed less on why adverse events materialized, and more on intervening when the event was harmful, adding to the apprehension that something dangerous could occur, contributing to a sense of insecurity and limiting recovery. Opportunities to discuss risks with staff were also reported as rare and seemed to contribute to a forebodingness to the hospital. Patient views about risks appeared not understood at times, as staff could attribute these to mental disorders with a focus on pharmacological treatment to address patient concerns.

> Not good medication because coming from people who do not understand me and demanding take, and take it. Better to talk about risks cos don't always know what is going on […] reality of their world is different from own reality. (P8)

> If you see a man on a roof, about to jump, you don't go up there and say, 'have some tablets first, that'll sort you out,' you have to talk him down. (P12)

The lack of comfort to promote a risk-free environment perpetuated a sense of forebodingness, involving removing items that could be weaponized or used for self-harm. Though participants acknowledged that risks existed with these objects, it intensified environmental uneasiness, especially when assumed these precautions lessened opportunities for risk-related conversations and exacerbated a lack of homeliness. Insecurity of the self could develop about ways to cope, as the hospital became interpreted around precariousness, inharmonious with what was seen as helpful within the lives of the patients.

> Definite risk assessment […] count the cutlery now or can't have China cups of tea anymore we have to have plastic ones […] we don't have a pool table anymore. (P4)

> Done the anti-ligature assessment […] communications with them will not be on [patient concerns] for spending time mitigating those risks in […] practical terms. (P6)

> Homeliness […] feeling of normality […] a feeling of, I don't feel threatened […] or I am going to be judged. (P13)

Subcategory 4: Management from afar

Observation rather than interaction appeared commonplace, and despite participant accounts about needing personal space, a balance was required with some staff interaction, and not feeling scrutinized from afar. Little clarity existed as to the purposes of observation adding to its unaccustomedness, with the suggestion that observations were indicative of staff mistrusting patient intentions, which could be internalized, raising a mistrust of the self.

> He didn't really engage, just observed me, he wasn't 'Oh, hello, what's your name,' or anything like that. (P7)

> Trust it wasn't there, I tried to understand myself and now no one understands me, complicated when you don't understand yourself and no one understands you. (P8)

Participants suggested patient behaviours were shaped somewhat via observations, raising questions about its purpose and what was recorded as identified by staff writing on clipboards. This added to a sense of insecurity with being scrutinized but short of a voice to provide different views. Hence without explaining the purpose of observations, seemed to perpetuate ontological insecurity with patients wondering what they were doing wrong.

> Is my life that monitored to the point, and it's almost 'X did this, this time and X went to the toilet this time. (P1)

> Observations are a need to mitigating risks but is that individual aware of what that risk is? Almost looking at a custodial sentence, so where is the discussion, where is the information, where is the level of respect? (P6)

> Judgement without asking, made [me] feel more abnormal being watched. (P10)

DISCUSSION

Although risk management is under scrutiny within inpatient settings, the study findings provided a unique perspective. Namely, how insecurity in the self may develop, theorized around ontological insecurity involving obstacles in gaining a meaningful grasp of risk management. Omitting to explain in ways that might be relatable resulted in questioning the reality happening to the patient, which could be internalized about the inability to make sense of the hospital (Gustafsson & Krickel-Choi, 2020). Hence, mistrust in the self could materialize, despite this trust already somewhat hampered by mental distress, while sense-making plays a vital role in recovery, such as with informed decision-making (Piltch, 2016). Noted with studies, similar disconnections can occur to what is meaningful owing to little justification for the hospital's daily activities (Molin et al., 2016). Equally, feeling excluded from risk management increases mistrust in staff and the self about ways to cope (Senneseth et al. 2022). Limitations with implementing recovery-orientated care appear to correspond with the experiences of the study participants. For example, the pharmacological focus on treatment in hospitals which restricts personal choices, and patients having little involvement with care planning by being asked to agree with ready-made plans (Newman et al. 2015; Waldemar et al., 2016).

Nevertheless, risk management in hospitals is notoriously complex (Boland & Bremner, 2013). As illustrated, there can be tension between promoting patient safety by restricting harmful behaviours, while being mindful of the need for patient participation in aiding recovery. It is not the case that mental health nurses who work within acute ward settings do not believe in recovery principles. On the contrary, from patients' perspectives, nurses can pay attention to respecting the individual's views on what is meaningful in life, drawing on these viewpoints to explain and promote patient participation in their care (Horgan et al., 2021).

Among reasons, staff may lessen patient involvement with risk management to mitigate fears about blame if there is an adverse risk event (Felton et al., 2018). Not only may staff encounter managerial scrutiny in such circumstances, but also scrutiny of the self around abilities to care, noted with compassion fatigue (Marshman et al., 2022). Clinical supervision may have value, an approach that assists with reflecting on opportunities to provide care. Given risk can be an emotive subject, a safe and compassionate space is needed to discuss risk-related anxieties supported by fellow team members. The discursive approach allows for understanding to develop while reflecting that addressing risk requires a team approach to ensure staff feel supported (Walker & Clark, 1999). When patients and clinicians feel enabled, collaborative risk management is possible, though further research appears required around how practitioners maintain a recovery approach when frequently encountering adverse events on a hospital ward (Hawton et al., 2022; Rimondini et al., 2019).

From the participant's perspectives, some of the findings may guide inpatient practices. Most noted they were severely ill when admitted to hospital, yet their experiences corresponded to research in which the acuity of illness can fluctuate (Llewellyn-Beardsley et al., 2019). This temporal state suggests opportunities early on to explain what is happening and involvement in risk management as well as what could improve recovery, yet within tolerance levels to engage which vary from patient to patient and within different times (Weber et al., 2022). The apparent rigour applied to mitigate risks could also be adopted by identifying opportunities to engage. Observation appears opportunity to open dialogue about personal views and needs, with an openness for the reason to observe (Cox et al., 2010). Being attuned to invitations to discuss patient understanding also appears helpful (Olson et al., 2014), as noted when Participant 15 asked about management rules. These factors may assist recovery early in the admission, and via building knowledge of the person beyond the condition, attempt to draw on their beliefs in making risk management more meaningful.

STUDY LIMITATIONS

Rather than ontological insecurity, other explanations might have been theorized, though the concept resonated with the views of the last two participants and the group lead assessing the authenticity of findings. The lack of sample diversity was another limitation, partly because the COVID-19 pandemic impeded recruitment. Patient views appear overlooked in risk management research, magnified for patients from minority groups, suggesting the sample did not reflect the diversity of those accessing the hospital. The sample is also not representative of all inpatient views but appeared sufficient to have utility about how risk management practices may, at least in some ways, impact patient recovery.

CONCLUSION

The study provided insights into the destabilizing nature of risk management, given a lack of patient understanding and participation in its practices when admitted to hospital. Through ontological insecurity, this can impact sense-making around a meaningfulness to care that aids recovery. Further research is needed to explore ontological insecurity in how it translates to other patient perspectives since risk management in this study confirmed that their personal views might be overlooked when there is a clinical focus on risk concerns.

CLINICAL IMPLICATIONS

Involving patients in enriching the meaningfulness of risk management appears to aid stability when admitted to hospital. While concern exists about mental distress, a way to know if participation is feasible is through attempts to engage the patients. Building such connectivity may not only improve understanding of the person but also aid sense-making which appears vital for recovery. Yet to engage, it is recognized staff need to feel supported owing to the possible blame culture associated with risk management.

AUTHOR CONTRIBUTIONS

KD conducted the PhD study fully, CW contributed to authoring the paper, IB reviewed the analysis while JW edited the paper and with CP, guided the study as PhD supervisors.

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CONFLICT OF INTEREST STATEMENT

No known conflict of interest at time of submitting the paper.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

The UK Health Research Authority (19/SW/0174. Date 12/11/2019) provided ethical approval while participant consented to be interviewed and disseminating their anonymized data.

PATIENT CONSENT STATEMENT

Participants were informed of the study purpose, and signed consent forms before interviews, while could leave the study at any time. If any distress occurred during the interview owing to the topic of risk, a debrief would be offered. Also offered was for participants to review the data analysis of their transcripts and if requested within a month, their contributions to the study could be removed. All participants consented to the dissemination of the findings in the form of conference presentations and publications.

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