Accora Academy



# 24-Hour care guide

Accora

# An introduction from
# Clinical team leader Nicola



**Welcome to our new 24-Hour care guide. Here we continue the conversation around around what truly meaningful, person-centred care looks like over a full day and night.**

As we move further into this **quarterly focus on 24-hour care**, it's a good moment to pause and reflect on what we're really aiming for. Not perfection. Not a single "right" solution. But care that feels joined-up, realistic, and grounded in the lives people are actually living.

As Occupational Therapists, we know that truly good 24-hour care isn't about a single assessment, a one-off intervention, or even the perfect piece of equipment (if only it were that simple…). It's about understanding the whole person- how they live, move, rest, and take part in everyday life across the full day and night.

In our **24-Hour care guide**, we've brought together practical insights, shared experiences, and a bit of real-world honesty around the things that really shape person-centred care. From clinical reasoning, to postural care, seating, sitting tolerance, and goal setting- to the everyday balancing act between comfort, activity, and 'what actually works'- it's all here.

This quarter builds on everything we've been exploring together so far, recognising that 24-hour care isn't a standalone concept- it's something we revisit, refine, and reframe over time, with every person we work with.

We've also included more reflective pieces on person-centred care, including a community blog inspired by conversations at our recent **24-Hour Care Conference in London**. Because as we all know, some of the most valuable learning doesn't come from textbooks… it comes from practice, from people, and from those honest chats over coffee.

We hope this guide feels useful, reassuring, and relatable- something you can dip into and think, *'yes, that's exactly what I see too.'* Most of all, we hope it supports OTs and wider care teams in making every hour of care just that little bit more thoughtful, connected, and meaningful for the people we work with.

Thank you for continuing this journey with us- and for the work you do every day to bring 24-hour care to life.

***Nicola Murphy***

# Meet the **clinical team**:

Accora Academy

**Our clinical experts are available for training and education opportunities but also to provide individual advice on a case-by-case basis.**

They can support clinicians with clinical reasoning and justification for solutions and product requests.



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# Clinical reasoning in Allied Health:
making our thinking visible

**with Jenny Rolfe**



## What is clinical reasoning?

Clinical reasoning sits at the core of safe and effective healthcare practice. For Occupational Therapists (OTs) and other Allied Health Professionals (AHPs),it underpins everyday clinical decisions- from assessment and intervention planning to risk management and person-centred care. Although clinicians often make these decisions quickly and intuitively, the ability to clearly articulate and document the reasoning behind them is equally critical for safe practice, professional accountability, and effective multidisciplinary collaboration (Higgs et al., 2024).

Clinical reasoning can be defined as the cognitive and decision-making processes clinicians use to gather information, interpret clinical cues, identify problems, plan interventions, evaluate outcomes, and reflect on practice (Vallente, 2024). In practice, it is the mechanism through which clinicians make sense of a patient's situation and determine the most appropriate course of action.

## Why clinical reasoning matters in Allied Health

In complex healthcare environments such as rehabilitation, community services, acute care, and social care, strong clinical reasoning allows AHPs to deliver safe care, make defensible professional decisions, manage uncertainty, and work autonomously. Importantly, it also enables clinicians to learn from experience through reflection, gradually refining judgement and expertise over time (Higgs et al., 2024).

## Making reasoning visible through documentation

One key aspect of clinical reasoning is that it happens continuously during patient interactions. Clinicians constantly interpret cues and adapt interventions in real time-for example, deciding whether a patient is safe to mobilise, recognising fatigue during therapy, identifying early signs of deterioration, or adjusting positioning during a seating assessment. These moment-to-moment decisions rely on clinical knowledge, pattern recognition, and professional experience.

However, while reasoning occurs continuously in practice, documentation is where reasoning becomes visible. Clinical records should clearly explain what was observed, what conclusions were drawn, and why particular interventions were recommended. For example, rather than simply documenting *"riser recliner chair recommended,"* stronger documentation would explain that the patient demonstrated increased effort during sit-to-stand transfers and fatigue from low seating, therefore a riser recliner chair is recommended to support safe transfers and reduce physical effort.

**Types of clinical reasoning:**

Research suggests clinicians draw on several forms of reasoning simultaneously:

1. Hypothetico-deductive reasoning involves forming and testing hypotheses during assessment, while pattern recognition allows clinicians to identify familiar clinical presentations from prior experience.

2. Narrative reasoning focuses on understanding the patient's story, goals, and values, while pragmatic reasoning considers environmental constraints and available resources.

3. Ethical reasoning ensures that patient autonomy, safety, and risk management are appropriately balanced (Higgs et al., 2024).

Strong clinical reasoning connects assessment findings to intervention decisions. Effective reasoning integrates multiple factors, including physical function, environmental barriers, psychosocial context, patient goals, and risk considerations. Clear justification of recommendations- such as explaining that a shower seat is required due to reduced standing tolerance and increased fall risk- supports transparency and continuity of care.

## Risks of poor clinical reasoning:

When reasoning is weak or poorly documented, significant risks can arise. These include patient safety issues, communication breakdowns within multidisciplinary teams, and legal or professional challenges if decisions are questioned. Research suggests that diagnostic error may occur in 10–15% of consultations, often linked to reasoning failures or cognitive bias (Levett-Jones et al., 2010). Clear reasoning and documentation, therefore, play an important role in reducing risk.

## Development of clinical reasoning:

Clinical reasoning skills develop through reflection and supervision.

***Reflecting*** "in action" during patient care and "on action" after clinical encounters helps clinicians analyse decisions and refine future practice.

***Clinical supervision*** provides opportunities to discuss complex cases, challenge assumptions, and strengthen critical thinking- particularly valuable for early career practitioners but beneficial throughout professional development.

Ultimately, clinical reasoning is not separate from clinical practice- it is clinical practice. Every observation, assessment, and recommendation reflects the clinician's reasoning process. By making that reasoning visible through clear documentation and reflective practice, AHPs can strengthen patient safety, professional autonomy, and high-quality care. Visible clinical reasoning strengthens not only individual decision-making, but also communication, accountability, and the overall quality of care.

## References:


Clinics in Integrated Care (2025) The importance of clinical reasoning in differential diagnosis for non-medical prescribers, nurses and pharmacists.

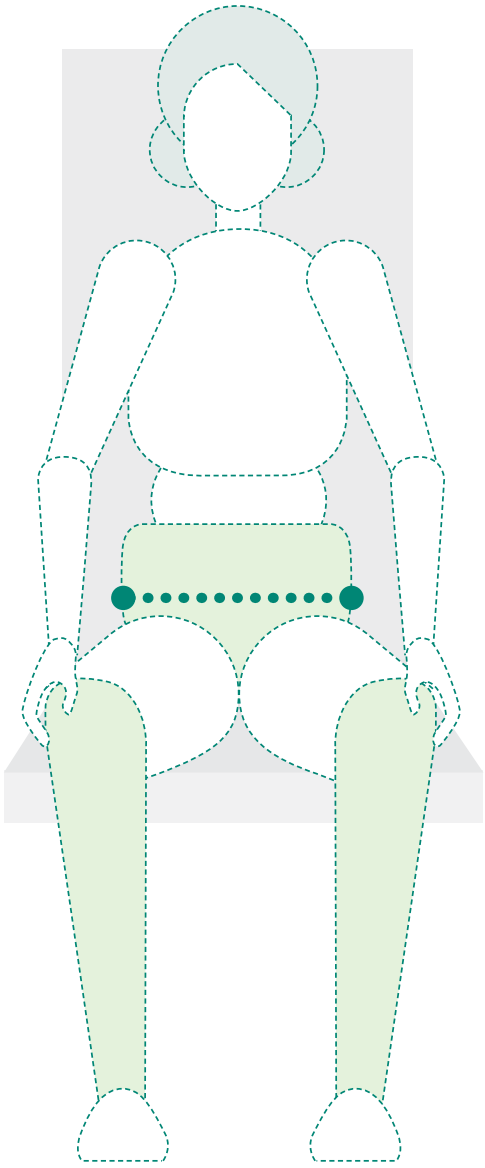
ECU Interprofessional Learning Manual (2023) Clinical Reasoning Literature Review.

Higgs, J., Jensen, G., Loftus, S., Trede, F. and Grace, S. (2024). Clinical Reasoning in the Health Professions. 5th ed. Elsevier.

Levett-Jones, T., Hoffman, K., Dempsey, J., Jeong, S., Noble, D., Norton, C., Roche, J. and Hickey, N.(2010) 'The five rights of clinical reasoning: An educational model to enhance nursing students' ability to identify and manage clinically at risk patients', Nurse Education Today, 30(6), pp. 515–520.

Vallente, R. (2024) Clinical Reasoning. EBSCO Research Starters.

# Good body segment alignment and symmetry = good posture



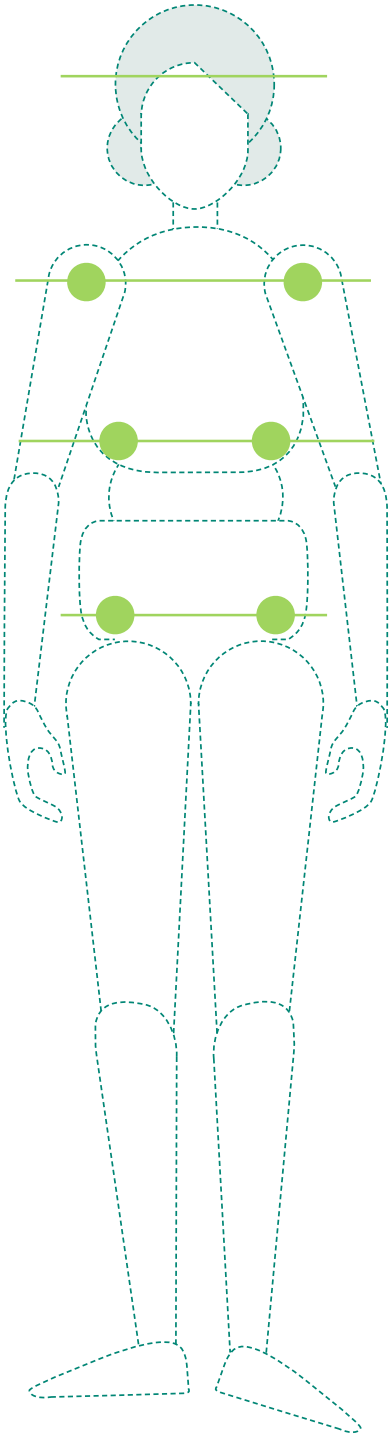
Head

Shoulders

Trunk

Pelvis

Limbs

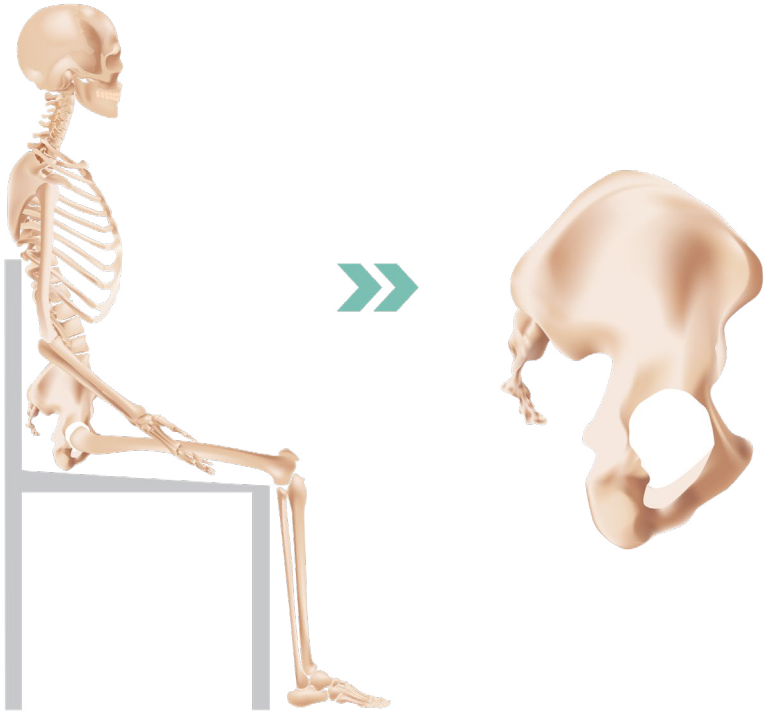


# Good sitting posture

Pelvic neutral

Pelvic symmetry

Good spinal alignment with natural curves



Hip joints: 90 degrees

Knee joints: 90 degrees

Ankle joints: 90 degrees



Even weight distribution

Body symmetry

# **Postural care:** warning signs, solutions and what you can do to help

## Be alert to early warning signs

If someone is starting to develop poor posture it will only get worse if we do not address it...



## Think...

Body alignment?

Weight distribution?

Is the pelvis stable?

High pressure points?

Body surface area in contact with supportive surface?

Limited range of motion for sitting 90/90/90

How well can the individual change their position?

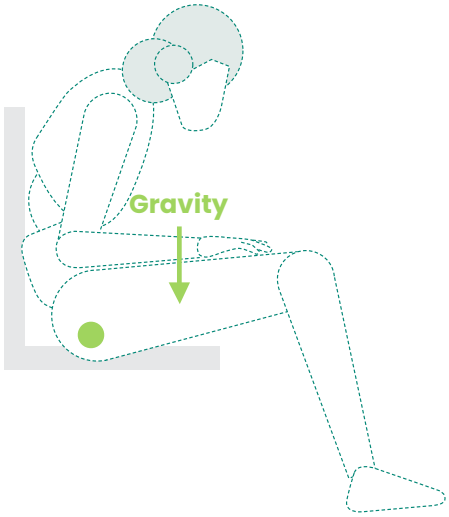
## Be alert to the presence of development of asymmetry in lying...

If someone is beginning to develop poor posture- such as leaning forwards or to one side while standing, sitting, or lying down- it's important to address it early. Without intervention, these postural changes are likely to become more pronounced over time.

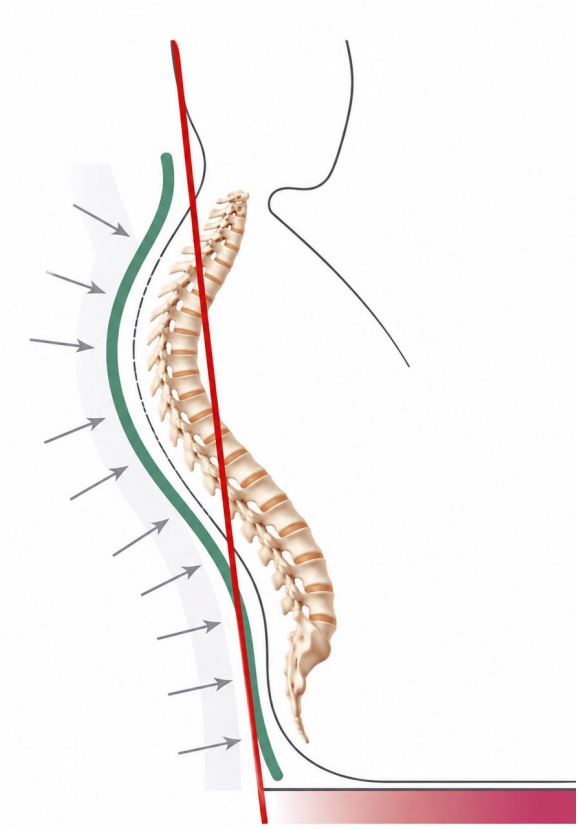


# What can we do?

**Look at adaptable seating that works with the person's posture- accommodating that fixed spinal asymmetry and using lateral supports to help maintain alignment and support function.**




Consider the impact of gravity...
Tilt-in-space will be your best friend!



Adjusting the backrest to accommodate back profile

- Chair too wide
- Leaning to the right - scoliosis
- Seat too high
- Increased weight to the right side



- Kyphosis accommodated- waterfall backrest
- Open Recline for reduced hip flexion
- Appropriate seat width with good arm support
- Even weight distribution



## For those with more complex body configuration

Supporting and accommodating spine profile to immerse into chair.

Accommodating limitation in hip and knee flexion and knee extension.

## Tilt-in-space supporting posture by off-setting gravity









# 24- Hour postural care

## Why every position matters

### Posture doesn't stop when sitting does...

- Postural and pressure care continue day and night
- Every position- sitting, lying, standing, transferring - affects alignment and skin integrity
- Continuous support maintains comfort, function, and safety





# Posture in lying

## Preferred posture in lying will determine posture in sitting

Assess posture in lying as well as in sitting to determine true position (reduced gravity)





# Benefits of 24-Hour postural care

**Protects body shape** and reduces postural deterioration

**Improves comfort and tolerance** across sitting and lying

**Supports function and participation** throughout the day

**Reduces risk of pressure injury** and secondary complications

**Facilitates care** and reduces manual handling demands

# What can you do?



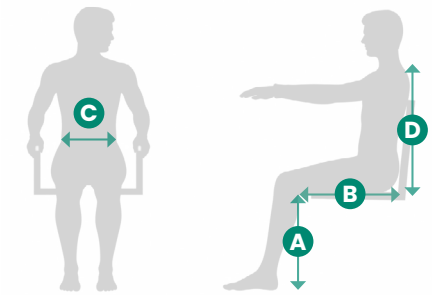
# Seating assessment

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| | | | |
|---|---|---|---|
| **Client name:** | | **Assessment carried out by:** | |
| **ID no/NHS no:** | | **Date of assessment:** | |
| **Address:** | | **Present at assessment:** | |
| **Tel no:** | | | |
| **Date of birth:** | | | |
| **Healthcare professionals involved** | | | |

| **Diagnosis / medical history / medical status** |
|---|
| |

| | | | |
|---|---|---|---|
| **Height:** | | **Weight:** | |

| **Measurements of the patient / service user** | | |
|---|---|---|
| Seat height (A) | |  |
| Seat depth (B) | | |
| Seat width (C) *(across hips)* | | |
| Back height (D) | | |



| | |
|---|---|
| Presenting problems / problems with current seating | |
| Mobility / transfers / manual handling | |
| Environment (doors, space, other surfaces, under tables etc.) | |
| Pressure issues / skin integrity (Purpose T result / previous pressure damage) | |
| Continence | |
| Perception / congnition / behaviour | |

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## Postural passport: seating

Silver Partner

Royal College of Occupational Therapists

Accora

This chair has been assessed for and set up for:

**It should not be used for any other resident.**

Any changes in position of chair and needs of residents should be made known to the nurse in charge as soon as possible in order for a review / repair / re-assessment to be made.

| Equipment | Type of equipment | Specific set up |
|---|---|---|
| Cushion | | |
| Backrest | | |
| Chair or wheelbase | | |
| Other (please specify) | | |

| Specific Instruction re positioning | | Photo (consent req.) |
|---|---|---|
| Hips | | Front view |
| Head | | |
| Arms | | |
| Legs | | |
| Feet | | |
| Trunk | | Side view |
| Transfer instructions | | |

Completed by: ..... Discipline: ..... Date: .....

Name: ..... HCPC Reg: ..... Contact number: .....

GEN-EDU-015UK Rev01

# Guide for selecting a pressure relieving cushion

Best option  Good option  Possible but not ideal

| Clinical factor | Foam | Gel | Static air | Hybrid | Alternating air |
|---|---|---|---|---|---|
| **Pressure ulcer risk:** Low-moderate | ✓ | ✓ | ▲ | ✓ | ▲ |
| **Pressure ulcer risk:** High-very high | ▲ | ✓ | ★ | ★ | ★ |
| Need for high postural stability | ★ | ✓ | ▲ | ★ | ▲ |
| Need to offload bony prominences (ITs) | ✓ (multi-layer) | ✓ | ★ | ★ | ★ |
| Pelvic obliquity / asymmetry management | ▲ | ✓ | ✓ (adjustable) | ★ | ▲ |
| Current pressure ulcer present (Stage II-IV) | ▲ | ✓ | ★ | ★ | ★ |
| Heat and moisture management | ▲ | ▲ | ✓ | ✓ | ✓ |

# Choosing the right mattress

Seating flowchart according to risk assessment, clinical judgement and taking into account essential considerations.

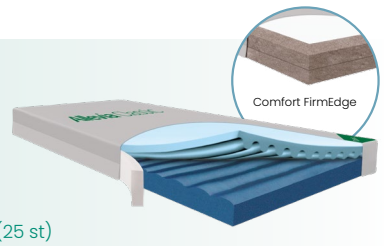
**Low risk**
**Waterlow below 10**
**Purpose T: green risk**
**Braden score: 19-23**

- Residents or service users with no, or low risk of pressure damage. Regular assessment is required.
- Diabetic residents or service users who are low risk, at-risk or have a pressure ulcer to their lower leg should always be considered for a mattress with a heel slope and/or heel protectors.
- Residents or service users should have both the ability and motivation to reposition themselves independently.

**At risk**
**Waterlow 10+**
**Purpose T: orange risk**
**Braden score: 15-18**

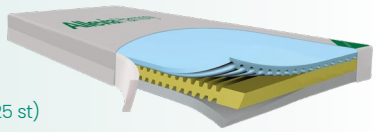
- If resident or service user has skin marking, or has existing pressure damage. Consider increased repositioning requirements and/or use alternative mattress.

**Allevia® Classic/ FirmEdge**
**Weight limit:** 160 kg (25 st)



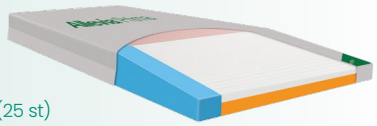

OR

**Allevia® Harmony**
**Weight limit:** 160 kg (25 st)



OR

**Allevia® Prima**
**Weight limit:** 160 kg (25 st)



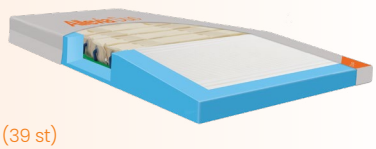
**High risk**
**Waterlow 15+**
**Purpose T: orange risk**
**Braden score: 13-14**

- Skin intact.
- Pressure ulcer present which is in contact with the mattress surface.
- If resident or service user has skin marking, or has existing pressure damage. Consider increased repositioning requirements and/or use alternative mattress.

**Very high risk**
**Waterlow 20+**
**Purpose T: red risk**
**Braden score: <9**

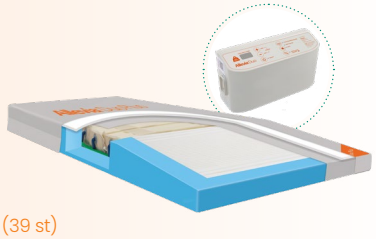
- Skin intact.
- Pressure ulcer present which is in contact with the mattress surface and not improving on previous mattress.
- If resident or service user has skin marking, consider increased repositioning requirements and specialist TVN advice.

**Allevia® Duo / Duo Plus** without pump
**Weight limit:** 248 kg (39 st)

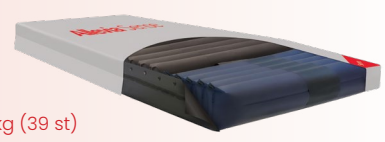


OR

**Allevia® Duo / Duo Plus** with pump
**Weight limit:** 248 kg (39 st)



**Allevia® Sense**
**Weight limit:** 249 kg (39 st)



# From sitting to doing:
why sitting tolerance must link to meaningful goals
**with Nicola Murphy**



## Let's be honest- no one wakes up thinking:
## 'today, I'm really going to work on my sitting tolerance.'

And yet… in our world, it quietly becomes one of the most important things we assess. Because here's the reality: ***if someone can't tolerate sitting, most activities of daily living don't really happen.***

### The reality behind 'just sitting'

We often talk about Activities of Daily Living (ADLs)- things like dressing, eating, washing- the basics of independence. But those everyday tasks rely on something we don't always call out enough: ***the ability to sit comfortably, safely, and for long enough to actually do them.***

Because sitting tolerance isn't just 'time in chair.' It's:

- comfort
- posture
- fatigue
- pressure risk
- ability to engage

You can have the best chair in the world… but if someone can only manage 20–30 minutes before discomfort or fatigue takes over:

- meals get rushed
- social time drops off
- participation reduces
- and time in bed creeps up

And suddenly, we're not talking about sitting anymore- we're talking about quality of life.

**And no…the chair isn't the whole answer**

One of the biggest myths is 'the seating is sorted'- if only it were that simple! Posture isn't just a chair-based issue- **it's a 24-hour conversation**.

We need to think about:

- What is happening overnight?
- Are they starting the day fatigued or misaligned?
- What happens during transfers?

All of these things feed directly into how well someone can sit, function, and participate.
So no- we can't just fix the chair and walk away (tempting though it is).

In a 24-hour care approach, the chair is only one part of the story. Bed positioning, rest, transfers, fatigue, and how the whole day is structured all affect whether someone can actually sit out, engage, eat, interact, and function comfortably. When day-time seating and night-time positioning work together, people are much more likely to manage meaningful activity with comfort and consistency.

### Where it really matters: goal setting

This is where things either come together… or completely fall apart.

We've all seen these written down:

- 'Improve sitting tolerance'
- 'Improve posture'
- 'Increase independence'

They sound right- but they don't actually tell us anything useful.

Good practice (and yes, HCPC/RCOT expectations) means our goals need to be:

- clear
- meaningful
- linked to real life

Not just nicely worded for a report.

## So… should we be using SMART goals?

**Short answer:** yes.
**Real answer:** yes- but don't overcomplicate it.

SMART goals get a bad reputation because they can feel a bit forced. But- in seating and postural care, they actually stop us writing vague goals that don't translate into real life.

Instead of thinking about all five letters, just ask:

- What are they doing?
- How long for?
- With what level of support?
- Why does it matter?

That's your goal.

## What this looks like in practice

**Let's take a common one:**
*'Increase sitting tolerance to 2 hours'*

**Try:** 'Sit out in chair for evening meal (45 minutes) with appropriate postural support, enabling safe eating and social interaction with family.'

**Another:**
*'Improve posture'*

**Try:** 'Maintain midline sitting to support safe swallowing during meals.'

**And one more:**
*'Increase activity'*

**Try:** 'Sit out of bed for afternoon visit without fatigue limiting engagement in conversation.'

## The bit we sometimes forget

Not everyone needs to sit out for hours, and not everyone cares about the same outcomes.

The goal isn't to hit a time target- it's to support a **routine and life that actually works for that person**.

## Why this matters

When you link:

- sitting tolerance
- posture
- meaningful activity
- real-life goals

You don't just improve sitting. You improve:

- mealtimes
- social interaction
- routine
- comfort
- dignity

Because sitting isn't the goal, participation is. Sitting tolerance is just one of the tools that gets you there. (An important one… but let's keep it in its lane!)

## Final thoughts

**If you're ever unsure, strip it right back:**
*What does this person need their day to look like?*

**Not:**

- 'What should the chair do?'
- 'What does the assessment say?

**But:** *'What actually matters to them?'*
Because once you've got that right- the goals, the seating, the positioning, they tend to follow. We are still OTs after all.

A CASE STUDY

# Configura® Comfort

## Tilt-in-space riser recliner

### Overview

Kerry is an older adult living in a private flat in Battersea with 24-hour live-in care. She uses a level-access shower with a wheeled shower chair and requires full assistance with all activities of daily living. Transfers are completed using a standing hoist. Kerry presents with lower-limb oedema and age-related functional decline, including reduced cognitive ability. She has experienced recurrent hospital admissions related to challenges in balancing hydration and oedema management.



### The challenge

Kerry's existing riser-recliner chair no longer met her needs. It was undersized, did not provide adequate pressure relief, and did not allow the standing hoist to position closely enough to facilitate safe and effective transfers, which negatively impacted her posture. Consequently, Kerry was frequently uncomfortable, unable to maintain optimal seated alignment, and spending increasing amounts of time in bed. She resides in a setting with an on-site rehabilitation unit, where she was reviewed promptly by the GP and nurse, and her oedema was regularly monitored.

### Assessment and clinical reasoning

The Occupational Therapist identified a clear functional decline and recognised the need to increase Kerry's time spent sitting out of bed. There was a strong clinical focus on improving posture, supporting oedema management, and reducing the risks associated with immobility.

A joint assessment was carried out with an Accora product specialist to explore an alternative seating solution that could better meet Kerry's needs.

### Intervention: Seating Solution

Kerry trialed the Accora Comfort Chair, which provided a number of key features tailored to her presentation.

The horseshoe-shaped frame cut-out enabled the standing hoist to be positioned safely and closely, significantly improving the quality and safety of transfers.

The addition of an elevating leg rest supported the management of Kerry's lower-limb oedema, while the integrated pressure-relieving cushion addressed her pressure care needs.

The chair also offered improved postural support, allowing Kerry to achieve a more stable and aligned sitting position.

Following the intervention, Kerry was able to spend more time sitting out of bed, which had a positive impact on her overall function and quality of life.

There were clear improvements in:

- Enhanced the safety and efficiency of transfers
- Improved seated posture and comfort
- Supported management of lower-limb oedema
- Reduced the risk of pressure injury
- Encouraged greater engagement in daily activities

The seating intervention meets Kerry's current needs while offering a sustainable solution as her condition evolves.

# **Editors review:** Person-centred care and the new standard for 24-Hour care

The landscape of modern medicine is undergoing a profound transformation. For decades, the primary focus of healthcare systems has been on treating diseases through a standardised, one-size-fits-all approach.

However, a new paradigm is emerging- one that places the individual, rather than the illness, at the very heart of the clinical experience.

Person-centred care (PCC) is no longer just a compassionate ideal; it is becoming a technological and clinical necessity that promises to make healthcare more sustainable, effective, and trusted (Coulter, A, 2016). This evolution is particularly critical in the context of continuous, 24-hour care, where integrated systems ensure that support is always available and tailored to the person's needs (Hoedemakers, M, et al, 2022).

## Beyond the diagnosis: a holistic view of health

At it's core, true personalisation in healthcare requires looking far beyond a patient's symptoms or diagnosis. It involves a sophisticated understanding of three intersecting dimensions- biological, clinical, and contextual factors- often referred to as the biopsychosocial model (Bolton, D, 2023) (ScienceDirect, n.d.). While biological and clinical data provide the 'what' of a patient's condition, contextual factors provide the 'why' and the 'how.'

| Factor Category | Description | Examples |
|---|---|---|
| Biological | The innate physiological and genetic makeup of the individual (ScienceDirect, n.d.). | Genetic markers, metabolic rate, microbiome composition. |
| Clinical | The documented medical history and current health status (Coulter, A, 2016). | Previous diagnoses, medication history, laboratory results. |
| Contextual | The social, environmental, and personal circumstances of the patient's life (Van Dulmen, S. A., 2013). | Living conditions, cultural beliefs, lifestyle choices, support networks. |

By integrating these three pillars, clinicians can move from a reactive model of care to a proactive, personalised strategy that respects the unique background of every patient, enabling continuous support and monitoring around the clock.

## The foundation of trust: listening and integrated data for continuous care

The journey towards person-centred care begins with a surprisingly simple yet foundational step: listening.

When clinicians take the time to understand a patient's concerns and goals, it fosters a level of trust that is essential for long-term health outcomes (Coulter, A, 2026). However, listening alone is not enough in our complex, modern world, particularly when aiming for comprehensive 24-hour care. This human connection must be supported by a robust digital infrastructure.

Personal health data should not exist in silos. For care to be truly seamless and available around the clock, information must be integrated across all settings- from primary care clinics to specialised hospitals and home-based monitoring systems (Hafiz, O, 2024).

When a patient's full story is available to every member of their care team at any given moment, it reduces the risk of errors, prevents redundant testing, and ensures that the patient feels known and understood at every touchpoint of their journey, regardless of the time of day (Zhang, Y, et al, 2022).

## Empowering clinicians and patients through technology for 24/7 support

One of the most significant challenges in implementing person-centred care, especially with the ambition of 24-hour support, is the increasing workload on healthcare professionals. Fortunately, technology is proving to be a powerful ally rather than a burden. By automating administrative tasks and streamlining documentation, digital tools can significantly reduce the 'clerical' burden on clinicians (Zhang, Y, et al, 2022).

This shift allows them to reclaim valuable time, which can then be reinvested into direct patient interaction- the very essence of person-centred care.

On the other side of the stethoscope, patient satisfaction is increasingly tied to the ease of access and the assurance of continuous support. Digital health records empower patients to take an active role in their own wellbeing by allowing them to view their medical history, schedule appointments, and access remote consultations with ease (PMC, n.d.).

In an era where we manage our lives through a few taps on a smartphone, healthcare should be no different, providing the peace of mind that support is available 24/7.

## A new standard for a sustainable future: person-centred 24-hour care

The transition to person-centred health, underpinned by the capabilities for 24-hour care, is rapidly moving from a futuristic concept to the new global standard. As technological breakthroughs in AI, big data analytics, and remote monitoring become mainstream, the potential to deliver highly effective, tailored care continuously becomes a reality for everyone (International Journal of Integrated Care, n.d.). This evolution promises a more sustainable healthcare system where resources are used more efficiently, and outcomes are consistently better.

Ultimately, putting the individual at the heart of healthcare, with the assurance of 24-hour support, is a shared victory. It creates a system where patients feel empowered and continuously cared for, and clinicians feel supported, leading to a healthier, more resilient society for us all.

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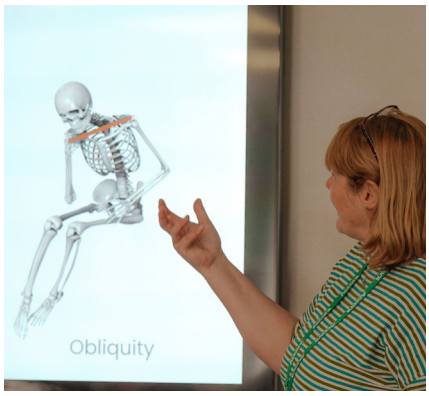
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# Accora's 24-Hour care conference




















# What does person-centred care mean to you?

Person-centred care is one of those phrases that everyone in health and social care uses, and almost no one defines the same way. It appears in policy documents, training materials, care plans, and inspection reports- yet ask ten clinicians what it means in practice, and you'll get ten different answers.

So at our recent 24-Hour Care Conference in Watford, we decided to do exactly that. We handed out a card with one prompt:

***'Person-centred care is…'***

And we asked attendees- Occupational Therapists, nurses, carers, prescribers, managers- to finish the sentence in their own words. No definitions, no prompts, no leading. Just whatever the phrase honestly meant to them.

What came back was a quiet, varied, deeply thoughtful picture of what good care really looks like.

***Listening came up more than anything else***

For a sector built around interventions, this was quietly telling. Again and again, attendees described person-centred care not as something you do, but as something you notice.

*"Active listening and resultant action/ interventions that reflect this for service users. They matter first."*

*"Listening to the person, observing and providing interventions to meet what is important to them."*

*"Person-centred care is listening to what the patients actually want regarding their care."*

*"Connecting with the patient before care."*

The first act of person-centred care, in the words of the people delivering it, is not doing something. It is paying attention- and then letting that attention shape what comes next. "Active listening and actions," as one attendee put it. The listening and the doing are inseparable.

## Following the person's pace, not the system's

**One response stayed with us:**

*"You follow the individual's pace, not the service timetable."*

Rotas, handovers, visit windows, equipment delivery slots- care systems are built around time. But the people doing the work were clear that person-centred care means letting the person, not the timetable, set the speed. Several others echoed the theme: care that adapts to the individual, "not one size fits all," "specific for that person's needs," delivered with dignity and "maximised independence" in a "calm environment, delivered by one carer where appropriate."

It is a small reframing with significant implications. It means care that flexes around the person, even when the system would find it easier the other way around.

## Seeing through their eyes

A surprising number of responses came back to perspective- the discipline of stepping into the other person's experience before deciding what's needed.

*"Putting yourself in their shoes, seeing how they see things."*

*"Looking through their eyes, not just assuming."*

*"Thinking about how we can be the tool to support clients achieving their potential."*

That last one is particularly striking- the idea that the clinician is the tool, supporting the person to live their life, rather than the other way around. It quietly inverts the usual relationship between professional and patient, and lands somewhere closer to partnership.

## The whole 24 hours, not just the appointment

Several attendees described person-centred care as something that has to hold up across the full day- not just the moments when a clinician is in the room.

*"Really considers whole person holistic needs for equipment, activity, roles, what they care about over life and during the 24-hour day."*

*"Person-centred care is to look holistically at person needs and comfort."*

**One Occupational Therapist captured it especially well:**

*"Placing the individual's unique goals, values and preferences, and enabling engagement in meaningful occupations rather than just treating a condition."*

Not a moment of care. A continuum of it.

And, simply: *"It's all about me"*

**The shortest response cut closest to the heart of it:**

*"It's all about me!"*

*Two others echoed the same feeling:*

*"Being valued."*

*"They matter first."*

Person-centred care, stripped right back, is care that recognises the person at the centre of it as a someone- not a someone-being-cared-for. A whole person, with a life, preferences, a pace, and a perspective of their own.

## Why this matters

There is no single definition of person-centred care in any of these responses, and we think that is the point. It is not a checklist or a framework. It is a stance- a way of seeing the person in front of you. It looks different in an OT assessment than it does in an overnight care visit, and different again on a hospital ward.

But the thread running through every answer was the same: person-centred care begins with paying attention to the person, on their terms, at their pace, across their whole day. Everything else- the equipment, the interventions, the plans- flows from there.

Thank you to everyone who stopped to write something down. These cards may look like a small thing, but together they make a quietly powerful argument for what good care really looks like.

## Hear from the experts

Discover what person-centred 24-hour care means in practice by watching our latest webinar: 24-Hour care: the person-centred approach.

Featuring Nicola Murphy, Jayne Brewer, Sarah Thompson, Dean Curson, and Tom Waplington.

Gain practical insights from our clinical team and explore our full collection of on-demand webinars at: https://accora.care/academy/webinars







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