Strategies for Enhancing "Person Knowledge" in an Older People Care Setting

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Abstract

This article presents findings from one part of a study about compassionate care – the development of person knowledge in an acute medical ward caring for older people. Appreciative inquiry, an approach to research that focuses on discovering what works well and implementing strategies to help these aspects happen more of the time, was used. Staff, patients and families participated in this study which used a range of methods to generate data including interviews and observations. Immersion/crystallization was used to analyse these data using a reflexive and continuous approach to extracting and validating data. Findings uncovered what worked well in relation to compassionate care. Knowledge of the person and ways of promoting this was a key dimension. Three main themes for the development of person knowledge were: 'making a connection and clicking', 'knowing the little things that matter', and 'not assuming how people want to be cared for'. The attributes of 'caring conversations' emerged through the analysis process which we suggest are crucial to developing person knowledge. The political and public focus on compassionate care makes it opportune to raise discussion around this form of knowledge in academic and practice debates.

Keywords

Compassionate care, Knowing the person, Relationships, care for older people, caring conversations

Improving compassionate care, which recognizes the humanity and individuality of each person, is an international endeavor (Yoon *et al*.,2012; Mantzorou & Mastrogiannas 2011). In particular the United Kingdom (UK), has a number of high profile publications in response to reports of unacceptable care which lacked compassion and effective communication (e.g. Francis 2013; Local Government Association, NHS Confederation & Age UK 2012). Consequently, the UK is playing a leading role in policy and practice developments in compassionate care (Department of Health 2012; Local Government Association, NHS Confederation & Age UK 2012). Such developments are intended to contribute to a shared culture in the National Health Service in which the patient is the priority. Increasingly, frameworks such as 'Our Culture of Compassion' (Care, Compassion, Competence, Communication, Courage and Commitment), (English Department of Health 2012); the Essentials of Care (New South Wales Department of Health 2009) and the Fundamentals of Care (Welsh Assembly Government 2003) are identified as central to nursing work and advocate the importance of knowing the patient as a person (English Department of Health 2012). These frameworks although focused on nursing, may have applicability to all health care professionals. They also have international relevance as the emphasis on compassion sits within an increasingly complex health care landscape often dominated by concerns about outcomes, efficiency pressures, productivity, and competence. The findings reported in this paper are one part of an appreciative inquiry study about compassionate care - development of person knowledge in an acute care setting caring for older people - conducted in the UK. Compassion is defined as:

*The way in which we relate to other human beings. It can be nurtured and supported. It involves noticing another person's vulnerability, experiencing an emotional reaction to this and acting in some way **with** the person, in a way that is meaningful for people. It is defined by the people who give and receive it, and therefore interpersonal processes that capture what it means to people are an important element of its promotion. (Dewar et al 2011p.62)*

The broader findings are already reported (Dewar and Nolan 2013) and the particular focus of this paper is identifying strategies for eliciting person knowledge that can be integrated into daily practice.

Compassionate care and the development of person knowledge

Person knowledge, or what is known about a person, has been central to nursing theory since the 1960s (Benner 1984, Carper 1978). Development of person knowledge takes time and involves developing trust which may be challenging in health care's fast-paced climate (Patients Association 2009; The Kings Fund 2013; Vogt *et al*.,2014; Zolnierek 2014). Nursing theorists have advocated the importance of person knowledge since the 1960s. Compassionate care is receiving renewed emphasis and increasingly recognised as an essential prerequisite in nursing, other health disciplines and internationally (Edvardson *et al*.2010; Goodrich & Cornwell 2008; Siegal 2013).
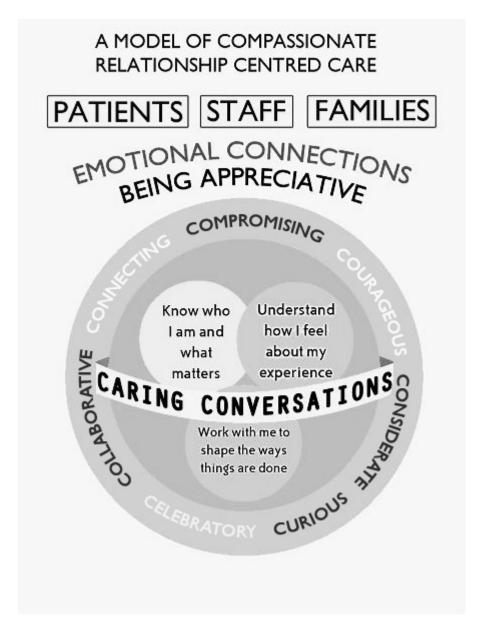
More recently, person knowledge, which distinguishes between 'what is known' about a person (e.g.age, condition) and 'knowing the patient' as a person (e.g.what matters to them, their past experiences), has emerged (Mantzorou & Mastrogiannas 2011). Liaschenko and Fisher (1999) helpfully make this distinction in their model of a knowledge script for

nurses. They identified different types of knowledge; case (biomedical scientific knowledge independent of the person/patient); patient (knowledge about an individual's response or reaction to illness or disease) and person (knowledge about the person as a unique individual) as important to caring (Liaschenko & Fisher 1999). It is claimed that person knowledge may not be afforded as high status as other types of knowledge (Liaschenko & Fisher 1999) but is essential to promote and maintain individual integrity (Liaschenko 1997). Maintaining individual integrity is a crucial aspect of the essentials of care and contributes to person-centred practice. (McCormack & McCance 2006).

Person knowledge is developed through knowing who people are and what matters to them in the context of health care which is a relational process. Health care professionals may not recognise instances in which they demonstrate person knowledge, indeed they may consider behaviour aimed at developing this carries a risk of engaging emotionally, or of opening a conversation in the absence of time in which to respond. Developing person knowledge, which tries to understand something about the patient as a person may also challenge the ethos prevalent within the care setting. Kim & Flaskerud (2007, p. 932) suggest nurses can be "…more comfortable repeating glib responses and maintaining a safe distance rather than risking attempts to connect". There is evidence that the culture within care environments facilitates or inhibits 'knowing the person' which requires interpersonal competence rather than technical expertise (Authors 2010, Macleod & McPherson 2007, Peters 2006; Schantz 2007; Schulz *et al.*, 2007, Von Dietze & Orb 2000; Youngson 2008). A review of person-centred frameworks places 'knowing the person' as a central dimension of compassionate care (Dewing 2004) and is therefore an area of significance for patients, families and practitioners.

Purpose of this paper
Dewar (2011) developed a model of compassionate care from an appreciative inquiry into compassionate relationship-centred care. The development of person knowledge emerged as a core dimension in the model for compassionate relationship-centred care (Figure 1) (Dewar and Nolan 2013; Dewar 2011).

A MODEL OF COMPASSIONATE RELATIONSHIP CENTRED CARE

PATIENTS · STAFF · FAMILIES

EMOTIONAL CONNECTIONS
BEING APPRECIATIVE

COMPROMISING
CONNECTING
COURAGEOUS
COLLABORATIVE
CONSIDERATE
CELEBRATORY
CURIOUS

Know who I am and what matters · Understand how I feel about my experience

CARING CONVERSATIONS

Work with me to shape the ways things are done

Details of all components of this model are previously reported. (Authors 2012; Authors 2013). Presented here is one action cycle from this appreciative inquiry, related to the development of person knowledge., 'Knowing who I am and what matters to me' and 'understanding how I feel about my experience' emerged as key strategies for enhancing the development of person knowledge (Dewar and Nolan 2013). This paper explicates the changes and strategies which emerged and the process of embedding these key strategies into routine nursing practice.

Methods

Overall Design. The appreciative inquiry (AI) took place in a 24 bedded medical ward for older people (> 65 years). Patients admitted to this ward had a range of medical conditions, including confusion and infections with many requiring end of life care. The average length of stay on the ward was 10 days. The AI approach builds on what is working well i.e. it explores what people value in what they do and how this can be built on, rather than focusing on problems (Clarke et al 2012; Cooperrider & Whitney 2000; Kowalski 2008; Reed 2007; Trajkovski et al 2015:Yoon et al 2011). AI as an approach differs from other qualitative designs in that it is orientated towards using positive experiences to identify knowledge. Language in AI is important to attribute meaning and understanding within a particular

context. Provocation is used to generate discussion and reflection in order to bring about change and AI is committed to the concept of inquiry as intervention (Bushe and Kassan 2005). In this study AI was combined with action research to an ensure emphasis on encouraging, developing and evaluating changes in practice. A collaborative approach between the researcher and key stakeholders, focusing on real time feedback, reflection and evaluation on positive attributes to develop practice, were central (Authors 2010; Egan & Lancaster 2005; Kavanagh *et al.,* 2008). The four principles of AI are that it is appreciative, applicable, provocative and collaborative (Cooperrider & Whitney 2000). . These principles underpinned all aspects of the study.

Following the discovery of practices that worked well, staff together imagined an ideal where these practices happened most of the time. They then developed sustainable approaches to achieving 'ideal practice' that were tested through cycles of change. This cyclical approach to the change process involved planning the innovation, testing it out, reflecting on implementation, re-designing and evaluating. The researcher, who is a nurse (first author) worked with the staff over a period of 3 months on this specific action cycle. The researcher and core participant group (3 registered nursing staff (all with more than 3 years experience) and 3 care assistants) collaborated through all phases of this action cycle to plan the development, co-analyse data and interpret the findings and subsequent action. Other action cycles developed as part of the overall study are reported elsewhere ('AUTHORS'2011). In the beginning staff were uncertain about the appreciative and participatory approach and as the study progressed they gained confidence over time and began to model an 'appreciative way' of working. This included noticing compassionate acts and talking openly and deliberately about these. This appreciative approach works on the premise that good practice is already happening and includes strong engagement from participants. It allows greater ownership of the development, less defensiveness and increases the chances of sustaining changes over time ('AUTHORS'2010).

Sample. A range of key stakeholders participated. This included Registered nurses (n=12), student nurses (n=9), non-registered care staff (n=8), allied health care professionals (n=4) and medical staff (n=2) (n=35 i.e. 85% of staff within the ward), patients (n=10) and families (n=12) (Authors 2011; Authors 2013). The sampling was purposive (Creswell 2003) in that participants were selected on the basis that they had an experience of giving or receiving care. Posters were displayed on the ward and patients and families were asked shortly after admission by the researcher or a member of staff if they would like to participate. Whilst all participants took part in the Discovery Phase of the appreciative action research study a core group (see above), participated in the development of the strategy in this action cycle. Not all of the patients and families contributed to each phase of the action cycle as they had left the ward.

Ethics

This study was approved by the University Ethics Committee (06/SNMSC/069). Due to the emergent design employed, ongoing process consent was used whereby consent was continually renegotiated. All participants were asked at each stage of data generation, feedback, implementation and evaluation if they wanted to continue to be involved.

Data collection

Data were generated in a number of ways (Table 1). The methods used were inclusive and participatory and aimed to learn about the experiences of participants particularly in relation to things that worked well in relation to giving and receiving caring and exploring what mattered to people. Exploration of beliefs and values, structured and unstructured observation and individual interviews were carried out with participants during the Discovery Phase of the appreciative inquiry. Information gleaned via one method informed data collection using

another method. For example, observation of specific interactions informed the focus and questions asked in individual interviews. During and following the implementation of the action cycle, informal interviews were carried out by the 6 members of staff in the core participant group and the researcher with other staff, patients and families, to ascertain what worked well and how their experiences of the intervention could be enhanced (see Table 1).

Table 1 – Data generation activities

• **Group Interviews with staff (discovery phase)**	• **Beliefs and values group interviews with staff (n=25 members of staff attended 8 sessions) to explore what they value as a member of staff and what they would value if they were a patient or family member in the ward**
• **Observation (discovery phase)**	• **Structured participant observations (n=10 events e.g. admission interview, team meetings). Researcher took notes of observed positive interactions and fed this back to staff for discussion and validation.** • **Informal observations carried out 2 days per week over 1 year – 240 hours**
• **Interviews to capture stories about experiences (discovery phase)**	• **Staff (n=10) and student nurse stories about experiences of giving care (n=9). Participants asked to describe a time when they were pleased about the care they gave. Notes were written at the time of interviewed and fedback to the participant in the form of a story for validation and discussion.** • **Patient (n=10) and family stories (n=12) were**

	carried out using emotional touchpoint interviews where participants were asked to talk about their experience and select emotional words that summed up how this felt.
• **Interviews to capture experiences of implementing action cycle (co-create phase of appreciative action research)**	• **Core participant group of staff (n=6) and the researcher interviewed staff (n=9), patients (n=6) and relatives (n=6) to capture the experiences of asking questions to find out more about the patient as a person. Questions were framed around what worked well and how can the experience of this approach be enhanced.**

Data Analysis

Data were analysed using immersion crystallization (Borkan 1999) and shared with staff to generate knowledge and practices that were able to be tested as part of the action cycles. Immersion crystallization involves initial description of the data; highlighting the core messages in data extracts; considering these in relation to other data; reflecting these back to participants; and a synthesis and further grouping of the themes. It is a thematic process which emphasizes reflection and collaboration. Emergent findings were analyzed and shared with participants where possible.

Results

The Discovery Phase uncovered what worked well in relation to compassionate relationship centred care. From this 'knowledge of the person' was identified as a core dimension. Three main themes emerged as part of this dimension: 'making a connection and clicking', 'knowing the little things that matter', and 'not assuming how people want to be cared for' ('AUTHORS' 2013)

Making a connection and clicking. A number of strategies which helped staff to 'make a connection and click' emerged:
- offering a warm welcome;
- sharing personal information with patients when appropriate;
- using humour to strengthen existing knowledge of the person.

Getting to know people in a professional context takes time. When time is short identification of communication skills and strategies to facilitate the process is vital.

Relationships needed to be built quickly to 'set the tone' for future interaction. Staff, patients and relatives talked about the importance of staff *welcoming* them to the ward, referring to them by name, and introducing themselves.

> I remember arriving in this ward, the ward clerkess welcomed me, and she knew my name and told the porters what bed I was going into. The nurses helped to slide me into my new bed; I was attached to drips and infusion pumps and oxygen. I was made very comfortable and offered a cup of tea and a sandwich. The nurse sorted out all my belongings and phoned my nephew to let him know I had moved wards. I was given an information booklet about the ward. It was very helpful. My nephew got the phone number of the ward and information on visiting time and a whole host of other information. (Patient Story, PS9).

Families welcomed daily interaction with staff and valued being asked how they were and for their views on relatives' progress plus the opportunity to ask questions. These actions helped build relationships and created openings for other conversations, supporting development of person knowledge.

Data demonstrated that staff, patients and families shared *personal information*; this facilitated relationships which in turn enhanced care-giving. Conversations that normalise the hospital experience were identified by one patient:

> I like talking to the nurses. We talk about everything and anything. I know a little about them too. I ask them what they are doing tonight – we talk normally. We don't talk much about what is wrong with me. I know what is wrong with me but I don't want to talk about that. (Patient Story, PS6).

Many staff valued sharing something about themselves with the patient with some (n=2) who did not consider it a legitimate part of their practice. The absence of validation from other staff that this was a valued part of engagement that enhanced relationships made some staff feel they were taking a risk when acting in this way. This quote illustrates also that not all patients wish to discuss their illness; sensitivity facilitates compassionate care and is a crucial component of person knowledge.

Staff, patients and families referred to the value of humor during interactions. One observation by the researcher noted staff joking with two patients whom they said they knew well. They felt it inappropriate to use humor with the other two patients in the four-bedded area as one was self-contained and the other quite unwell. Thus staff discerned when to use humor in interactions and needed first to know the patient as a person and anticipate their response. Family members also commented on the value of humor:

You have to take part in the banter (joking)– because that's the way it happens. Basically staff are looking after people who are dying – it is not easy for them and the banter can be a bit of a release. I like the banter. It's part of feeling they trust me. I feel privileged and accepted that they include me in the banter. You have to be careful though – I don't think I would start it but I can join in**. (**Relative story RS3) (Authors 2013; Author 2011).

This quote highlights that the use of humor can have positive outcomes for people which include feeling included and trusted but is dependent on knowing the person. Humor can be a useful strategy in developing connections with some patients which in turn can help

to develop person knowledge. Strategies of a deliberate welcome, personal sharing and the use of humor emerged as important in the development of person knowledge which helped practitioners to establish relationships.

Knowing the little things that matter. Patients valued staff's knowledge of their individual likes and dislikes and this seemed to move their care experience from ordinary to excellent. Reciprocity was evident where staff gleaned knowledge about the patient and used this to enhance the care experience for the patient and themselves:

> She (the patient Beth) sometimes becomes agitated and would be searching for keys or a door to get out and go home. One staff member, when finding out about her work in the beauty section of a department store asked her for a hand massage. Beth was given the hand cream and proceeded to do the hand massage to the staff member. Beth said to the staff nurse that she 'had let her hands go' and they needed quite a bit of attention. The staff nurse laughed and thanked her for this and asked if she would like her to massage her hands. They both had a thing going – with hand massaging. This really helped Beth to become more relaxed and the staff enjoyed this too. (Registered Nurse Story, SS3).

This quote illustrates use of knowledge about the person to influence care provision, benefitting both staff and patient. One registered nurse identified the importance of finding the special aspects that comprise the person:

> She got quite poorly … and eventually she lost consciousness. Her husband was coming in every day – they had been married for over 50 years. … I was looking in her toilet bag and I found her makeup. I thought she used to put it on herself so I thought I would put it on. I don't know if she was aware that I was doing this for her because she was unconscious. ... When her husband came in, he came out of the room and said 'who put her makeup on?, she looks lovely, she looks like herself'. (Registered nurse Story, SS9). (Authors 2013; Author 2011)

This registered nurse used her knowledge of the person in carrying out care and her actions were validated by the relative. This example highlighted the challenges of finding out about 'the person' who was unable to provide information. Additional skills of responding to cues, and asking relatives, were important. However, if this process is key to compassionate caring it raises issues about equity if, for example, it takes longer to find out the *little things that matter* to a person unable to communicate verbally. It raises questions about whether it would be possible to do these 'small things' for **all** patients and, if not, how decisions could be made about who should receive this care.

Staff gained knowledge of the person formally and also informally, in conversation, about what mattered to patients and this was supported by evidence from observations:

> Discussion took place at a multidisciplinary team meeting about a lady who was hoping to get home in the near future and a home visit had been planned. There was a lot of discussion about her mobility and her wound. The consultant then said – 'the thing the patient is most worried about is will the chair get through the door – have we checked this out?' (Field notes from observation 5).

One consultant physician (a research participant) leading team meetings often demonstrated person knowledge by identifying aspects important to individual patients and challenging staff's thinking, thus modeling a way of interacting for other staff to follow. Others then volunteered information about the little things that mattered to the patient and this 'set the tone' for using person knowledge to enhance care delivery.

Staff tried to incorporate little things that they knew mattered to patients, i.e. person knowledge, into their routine due to the relationship they established, even those that might be disapproved of by colleagues:

> One nurse really stood out for me. She took me downstairs for a cigarette. The Doctors might not think this is a good thing but it is good for me – it is all I have left to enjoy now. (Patient Story, PS6).

This quotation highlights risks taken by staff to enhance the patient's care experience. Actions not only met the specific needs of the patient but staff gained satisfaction from knowing, and acting on, the *little things that mattered* to people:

> I know just how much talc she likes and that she doesn't like spray on her body – that she likes me just to spray her clothes. It makes you feel good when you know about these things because you feel you are really giving the care that they want. (Non Registered Nurse Story, SS8).

Through the process of research and reflection on the data staff began to question the extent to which they always asked about the *little things that mattered* and the extent to which they may sometimes have made assumptions.

Not assuming how people wanted to be cared for. Initially, staff views were based on how *they* would wish to be cared for or how they would like *their* family to be cared for:

> Compassionate care is about caring. It's about loving, treating others like you would want to be treated yourself, going the extra mile. (Registered Nurse Story SS13).

This personal philosophy seemed to influence care. Staff felt deeply about others' vulnerability and used their own beliefs and values to influence care-giving. Staff did not check on a regular basis whether patients' perspectives were similar to their own. However, as the study developed and staff heard patients' stories, their thinking changed:

> I've really learnt that what I think is important and right might not be what the patient thinks. This has been hard because sometimes something that they think is important – I don't necessarily agree with, and I have to take a step back and think- well that is not what I think but let's go with it. I feel more confident with this and that others will support me. (Registered Nurse, recorded during field work, Nov 2008).

The importance of avoiding assumptions about care was highlighted by staff. Comments by patients challenged staff perspectives. For example, some staff assumed that lengthy visiting times were enjoyable for all patients. This view was challenged:

I enjoy visiting time [but] I chase my family out after half an hour, we all run out of things to talk about and it can be tiring. I don't expect them to visit twice a day, in fact once a week would be fine. (Patient Story, PS8).

Considering others' perspectives was associated with risk, as exemplified by one registered nurse:

We make a lot of assumptions about what people want – it's hard to check this out because sometimes you are worried that they will ask to be cared for in a way that you can't. (Registered nurse, recorded during field work, Nov 2008).

The majority of staff were receptive to challenges to their assumptions, responding with surprise and interest and developing their knowledge of the person. This stimulated a fundamental shift in communication with patients. Considering perspectives of others was key to developing person knowledge. During the envision phase of appreciative action research, where staff debated and discussed evidence from the Discovery Phase, they talked about their aspirations for sharing more widely knowledge about the patient as a person in the team. They realised that the little things that mattered were not necessarily always communicated to the rest of the team and a more systematic process for developing person knowledge and sharing this was required.

'All About Me' Questions

As part of the action cycle and the co-create phase of appreciative action research, the 6 core members of the participant staff group developed questions with a number of patients and relatives (Table 2) that would support getting to know more about patients as people and strategies that would help to share this information with the wider team. The questions were not meant to be a blueprint for knowing fully about the person behind the patient but rather as a starting point for staff to begin to develop some knowledge about the whole person rather than just their diagnosis and treatment plan in a busy acute setting. Questions were used at the admission process and throughout the patient's stay. The core participants and researcher carried out informal interviews with staff, patients and family members to explore the experience of using these questions.

Table 2: The 'All About Me' questions

All about me
What would you like staff to call you?
Who are the people closest to you and who do you want us to communicate with?
What are your thoughts and feelings about being in hospital?

What is your understanding of why you are in hospital?

Is there anything that is worrying you about being in hospital?

Is there anyone you would like to speak to? (doctor, chaplain, family member, friend,

neighbour)

What is important to you while you are in hospital?

What support do you need from the people that care for you?

A number of issues emerged from using the 'All About Me' questions in practice. Staff found asking certain questions and dealing with responses emotionally challenging. For example, in relation to the question, 'What is important to you?' one patient responded by saying they wanted to die. Another patient, when asked about why he was in hospital, said he knew he was not going to get better. The unpredictability of patients' responses provoked anxiety for some staff. Providing opportunities for staff to discuss their learning was important and often happened at informal meetings such as handover.

Staff needed support and this included opportunities to reflect with colleagues. Many questions in the framework were personal. Staff made decisions during the patients' admission about questions to ask at that time and those that should be left until a relationship was built with patients and their families. It became evident that questions in themselves were insufficient to change interpersonal practice; opportunities for further discussion with patients and families were required, as was discussion amongst staff.

A set of questions were a useful aid memoire and had the potential to become a checklist for completion that overshadows important relational processes in getting to know the person and what matters to them.

Deeper analysis of data was carried out in the broader study carried out by 'AUTHORS' of which this action cycle was part. Key interpersonal attributes (presented as the 7 c's framework of caring conversations) were identified in the wider study that supported staff to develop their person knowledge and deliver enhanced compassionate care (Table 3).

Table 3 Attributes of Caring Conversations

Attribute	Questions

Being Courageous	What matters to you? What would happen if we gave this a go? What would help you to give this a go?
Connecting emotionally	How do you feel about….. I feel……….
Being Curious	Help me to understand……Why do you think that happened? What is important to you while you are here? What would help you now?
Collaborating	How can we work together to make this happen? How would you like to be involved? What would you like us to do?Who else could help us?
Considering other perspectives	What do you think? What are others saying about this? Do we need to find out what others think? How do you feel about what others have said?
Compromising	What is real and possible? How can we work together to make this happen?
Celebrating	Has it worked well in the past? What happened? What works well for you? I value the fact that you are…….? Thank you for………

Dewar and Nolan (2013) suggests that this framework can be used to facilitate conversations that optimize cultures within which compassionate relationship centered care can flourish.

It is suggested that these 7 attributes should guide conversations to develop person knowledge, leading to shared understanding and agreed plans of care, alongside set questions such as those in 'All About Me'. Early findings from further work examining use of these attributes in practice confirm that the framework can support staff to develop their own questions, thus increasing ownership and the likelihood of sustainability in practice.

Discussion

Findings from this study are consistent with literature and theory related to the importance of 'knowing the person' within care relationships (Bridges *et al.,* 2009; Dewing 2004; McCormack 2004; Nolan *et al.*, 2006; Walsh & Kowanko 2002; Zolnierek 2014). The political and public focus on compassionate and dignified care makes it opportune to raise person knowledge in academic dialogue and debate (Ball *et al.*, 2013). Person knowledge is a fundamental requirement to inform nursing practice for older people therefore we need to move beyond knowing that person knowledge is important towards illuminating some of the 'know how', limited in current literature, around developing such knowledge.

The strategies identified as part of this study in developing person knowledge reflect the transactional nature of care. A key challenge is to build strategies into daily care routines which foster person knowledge (Brown Wilson *et al.,* 2009). To do so require involving the key stakeholders in such developments as in the work reported here.

Development of the 'All About Me' questions and the caring conversations framework in this study provided a structure to enhance person knowledge in daily practice, a key aim of this action cycle. The need to do so is reported in systematic reviews (Bridges *et al.,* 2009, 2011) which identify knowing the patient as 'see who I am', a key process valued by patients, families and staff in care settings for older people. The approach of appreciative action research built on existing good practices and aspects that mattered to those involved. This meant that the direction of the research was co-created by those that were to live with the consequences of any developments in practice. It ensured that the 4 principles of appreciative action research were lived out: the research was appreciative, applicable, provocative and collaborative.

A challenge in the acute care setting is the short timescale (1-10 days) available within which to develop person knowledge. In the community setting establishing relationships in order to 'get to know patients' can be paced (Kennedy 2004). We suggest that person knowledge is equally important and achievable in brief clinical encounters. Ways need to be found to incorporate strategies which help clinicians gain person knowledge within a short space of time. We caution against the inherent problems of reducing such care to 'tick lists'. The complexity and transactional nature of person knowledge means that uncertainty will pervade clinical situations and risk taking will remain a fundamental part of clinical practice and judgment. The 'All About Me' questions can facilitate establishment of person knowledge and should be used and adapted using the caring conversations framework with the person and the context in which care delivery occurs. This is not intended to be prescriptive but rather a 'scaffold' for person knowledge which can be adapted and shaped.

The majority of participants in this study were registered nurses however there is a growing recognition across health professionals of the importance of person knowledge. For example 15 physicians were asked 'What question(s) do you typically ask your patient that you feel contribute to your knowing your patient as a person? (Hanyok *et al.,* 2012). Many

resonate with the questions asked in 'All About Me'. Our findings suggest that additional questions which could be worth considering further include:' If I could do one thing to make you feel better, what would that be?' 'What are you hoping for in your interactions with me?'

Interactions to enhance person knowledge have been important in the way that GPs (Fairhurst & May 2011) and community nurses (Kennedy, 2002, 2004) attribute meaning to their work. Practitioners and practice areas need to consider the available frameworks and use these to enhance person knowledge. Contemporary health care practice is challenged to ensure person knowledge is a fundamental part of compassionate and dignified care. A survey of 2917 nurses identified that 66% reported having insufficient time to comfort or talk to patients (Ball *et al.,* 2013). Our findings suggest the use of key questions, during brief interactions, has the potential to improve person knowledge and provides reciprocal benefits for givers and receivers of care.

We propose this study adds to understanding of the 'know how' or practical knowledge required in person knowledge and helps to legitimize this fundamental element in care provision. Such knowledge is complex and influenced by the context in which care is given. Our findings suggest that strategies can help to improve person knowledge and embed relationship centered care into the culture of healthcare provision. In healthcare, where the nature of 'care' is under close scrutiny and where the way a patient is treated *as a person is* seen as a cornerstone of quality (Goodrich & Cornwell 2008), it is important to name, value and defend person knowledge to enhance patient care and to prepare health care professionals of the future.

Conflicts of Interest
The Authors declare that there is no conflict of interest.

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