Strategies for Enhancing “Person Knowledge” in an Older People Care Setting

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Abstract
This article presents findings from a study about compassionate care—the development of person knowledge in a 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 most 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 analyze these data using a reflexive and continuous approach to extracting and validating data. Findings uncovered that knowledge of the person and ways of promoting this were key dimensions of compassionate caring. 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

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Improving compassionate care, which recognizes the humanity and individuality of each person, is an international endeavor (Mantzorou & Mastrogiannas, 2011; Yoon, Roberts, Bowers, & Lee, 2012). In particular, the United Kingdom 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, National Health Service [NHS] Confederation, & Age UK, 2012). Consequently, the United Kingdom 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 NHS in which the patient is the priority. Increasingly, frameworks such as “Our Culture of Compassion” (Care, Compassion, Competence, Communication, Courage, and Commitment; Department of Health, 2012), the Essentials of Care (New South Wales Department of Health, 2014), 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 (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 article 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 United Kingdom. Compassion is defined as follows:

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, Pullin, & Tocher, 2011, p. 32)

The broader findings are already reported (Dewar & Nolan, 2013), and the particular focus of this article 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 (The King’s Fund, 2013; Patients Association, 2009; Vogt, Ulrestad, Polit, & Getz, 2014; Zolnierek, 2014). Nursing theorists have advocated the importance of person knowledge since the 1960s. Compassionate care is receiving renewed emphasis and increasingly recognized as an essential prerequisite in nursing, other health disciplines, and internationally (Edvardsson, Fetherstonhaugh, & Nay, 2010; Goodrich & Cornwell, 2008; Siegel, 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-centered 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 recognize instances in which they demonstrate person knowledge; indeed, they may consider behavior 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 and Flasquerud (2007) suggest nurses can be “. . . more comfortable repeating glib responses and maintaining a safe distance rather than risking attempts to connect” (p. 932). There is evidence that the culture within care environments facilitates or inhibits “knowing the person,” which requires interpersonal competence rather than technical expertise (Dewar & Mackay, 2010; Macleod & McPherson, 2007; Peters, 2006; Schantz, 2007; Schulz et al., 2007; Von Dietze & Orb, 2000; Youngson, 2008). A review of person-centered 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.
Figure 1. A Model of Compassionate Relationship Centred Care.

**Purpose**

Dewar and colleagues (2011) developed a model of compassionate care from an appreciative inquiry into compassionate relationship-centered care. The
Development of person knowledge emerged as a core dimension in the model for compassionate relationship-centered care (Figure 1; Dewar & Nolan, 2013; Dewar et al., 2011). Details of all components of this model are previously reported (Dewar & Nolan, 2013; Dewar et al., 2011). 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 & Nolan, 2013). This article explicates the changes and strategies, which emerged, and the process of embedding these key strategies into routine nursing practice.

Method

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, that is, 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, Schmied, Vickers, & Jackson, 2015; Yoon, Lowe, Budgell, & Steele, 2011). AI as an approach differs from other qualitative designs in that it is orientated toward 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 to bring about change, and AI is committed to the concept of inquiry as intervention (Bushe & Kassam, 2005). In this study, AI was combined with action research to 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, was central (Dewar & Mackay, 2010; Egan & Lancaster, 2005; Kavanagh, Stevens, Seers, Sidami, & Watt-Watson, 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 (three registered nursing staff [all with more than 3 years experience] and three care assistants) collaborated through all phases of this action cycle to plan the development, co-analyze data, and interpret the findings and subsequent action. Other action cycles developed as part of the overall study are reported elsewhere (Dewar et al., 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 and less defensiveness and increases the chances of sustaining changes over time (Dewar & Mackay, 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; that is, 85% of staff within the ward), patients (n = 10), and families (n = 12; Dewar & Nolan, 2013; Dewar et al., 2011). 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 whether they would like to participate. Although 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 used, ongoing process consent was used whereby consent was continually renegotiated. All participants were asked at each stage of data generation, feedback, implementation, and evaluation whether 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 care 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 AI. 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 six 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).

**Data Analysis**

Data were analyzed 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-centered 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” (Dewar & Nolan, 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 humor 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 caregiving. Conversations that normalize 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; Dewar, 2011; Dewar & Nolan, 2013)

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; Dewar, 2011; Dewar & Nolan, 2013)

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, that is, 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 caregiving. 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 realized 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 six 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.

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

<table>
<thead>
<tr>
<th>All about me</th>
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<tbody>
<tr>
<td>What would you like staff to call you?</td>
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<tr>
<td>Who are the people closest to you, and who do you want us to communicate with?</td>
</tr>
<tr>
<td>What are your thoughts and feelings about being in hospital?</td>
</tr>
<tr>
<td>What is your understanding of why you are in hospital?</td>
</tr>
<tr>
<td>Is there anything that is worrying you about being in hospital?</td>
</tr>
<tr>
<td>Is there anyone you would like to speak to (doctor, chaplain, family member, friend, neighbor)?</td>
</tr>
<tr>
<td>What is important to you while you are in hospital?</td>
</tr>
<tr>
<td>What support do you need from the people who care for you?</td>
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</table>
important to you?” one patient responded by saying he or she 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 among 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 Dewar (2011) of which this action cycle was part. Key interpersonal attributes (presented as the seven 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). Dewar and Nolan (2013) suggest 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 seven 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, Flatley, & Meyer, 2009; Dewing, 2004; McCormack, 2004; Nolan, Brown, Davies, Nolan, & Keady, 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, Murrells, & Rafferty, 2014). 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 toward 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, Davies, & Nolan, 2009). To do so requires 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; Bridges, Flatley, & Meyer, 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 who were to live with the consequences of any developments in practice. It ensured that the four principles of appreciative action research were lived out: The research was appreciative, applicable, provocative, and collaborative.

### Table 3. Attributes of Caring Conversations.

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being courageous</td>
<td>What matters to you? What would happen if we gave this a go? What would help you to give this a go?</td>
</tr>
<tr>
<td>Connecting emotionally</td>
<td>How do you feel about . . . . . I feel . . . . . . . . . . . . . . . . . .</td>
</tr>
<tr>
<td>Being Curious</td>
<td>Help me to understand . . . . . Why do you think that happened? What is important to you while you are here? What would help you now?</td>
</tr>
<tr>
<td>Collaborating</td>
<td>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?</td>
</tr>
<tr>
<td>Considering other perspectives</td>
<td>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?</td>
</tr>
<tr>
<td>Compromising</td>
<td>What is real and possible? How can we work together to make this happen?</td>
</tr>
<tr>
<td>Celebrating</td>
<td>Has it worked well in the past? What happened? What works well for you? I value the fact that you are . . . . . . . . . . . ? Thank you for . . . . . . .</td>
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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 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 that 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 mean 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, Hellmann, Rand, & Ziegelstein, 2012). Many resonate with the questions asked in “All About Me.” Our findings suggest that additional questions, which could be worth considering further, include the following: “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 General Practitioners (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 2,917 nurses identified that 66% reported having insufficient time to comfort or talk to patients (Ball et al., 2014). 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 health care provision. In health care, 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.

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Author Contributions

Study design and data generation—B.D. led with supervision from C.K. Preparing and critically reviewing manuscript—B.D. and C.K.

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References


