**The importance of building trust and tailoring interactions when meeting older adults’ health literacy needs**

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**Abstract**

**Purpose:** Health literacy is the ability to access, understand and use health information. This study qualitatively explored the views and experiences of older adults with varying health literacy levels who had attended a falls clinic on their overall experience of the falls clinic, access to the service and provider-patient interaction.

**Methods:** Individualsemi-structured interviews were conducted with nine older adults using a falls clinic in England. Health literacy was assessed using the REALM and NVS-UK. Interviews were audio-recorded, transcribed verbatim and interrogated using interpretative phenomenological analysis (IPA).

**Results:** Two superordinate themes emerged from the analysis: The importance of trust and relationship building to achieve effective communication with older adults; and the importance of tailoring education and healthcare to older adults’ individual health literacy needs and preferences.

**Conclusions:** The findings corroborate previous research emphasising the importance of face-to-face communication in responding to older adults’ individual health literacy needs. Building trust in the relationship, and tailoring communication to older adults’ individual attributes and preferred learning styles is essential.Healthcare practitioners and managers should consider how service organisation and communication methods can enhance positive and effective relationships with patients. Improved training could support healthcare providers in meeting patients’ personal communication needs.

# Introduction

Population ageing is a significant economic and social challenge in the UK ([1](#_ENREF_1)), with the number and proportion of older people living with long-term conditions increasing proportionately ([2](#_ENREF_2)). This could result in an unaffordable increase in health and social care costs ([3](#_ENREF_3)). The healthcare system continues to evolve in response to these demographic changes, and several specialised services have been created. Specialist falls prevention services are typical of emerging services for older adults.

Approximately one in three community-dwelling older adults fall each year and the risk increases with age ([4](#_ENREF_4)). Falls often have significant consequences for individuals, including increased rates of mortality and morbidity and have extensive financial costs for society ([4-7](#_ENREF_4)). Individuals who fall often have long-term conditions and other multiple co-morbidities ([8](#_ENREF_8)). Positive engagement with the healthcare system, combined with effective self-management has been advocated as the key to promote uptake and adherence of falls prevention activities and as one way of managing costs associated with an ageing population ([9](#_ENREF_9), [10](#_ENREF_10)).

Older adults need to be adequately equipped to access, understand and use health information in ways that enable informed decision-making, effective participation in healthcare and successful self-management of long-term conditions. This set of skills is often referred to as ‘health literacy’. There are many definitions of health literacy ([11](#_ENREF_11)); however all definitions in current use have at their core ‘the ability to access, understand and use information for health’. Low health literacy levels have been associated with reduced participation in prevention activities, less effective self-management of long-term conditions, greater unplanned healthcare and poor health outcomes ([12-15](#_ENREF_12)). Population surveys indicate high levels of inadequate health literacy with a high prevalence in older people ([13](#_ENREF_13)).

In their model identifying the causal pathways linking health literacy to health outcomes, [Paasche-Orlow and Wolf (16)](#_ENREF_16) proposed that health literacy and health outcomes are influenced by patient, provider and system factors. As such, health literacy is conceptualised as an interaction between an individual’s literacy skills, the complexity of the healthcare system and specific tasks required for self-management.

Health literacy can be improved through the provision of information, effective communication and structured patient education ([17](#_ENREF_17)). Patients can advance through functional skills in applying new information to prescribed activities, to more interactive health literacy skills that enable them to engage more meaningfully in health care decisions, to more critical health literacy reflecting more advanced cognitive skills to critically analyse and apply health information in changing circumstances ([18](#_ENREF_18)).

Enabling older adults to access, understand and use information to make informed choices and engage in effective self-management can be a challenge for healthcare providers. This challenge is compounded by the fact that readily available printed healthcare materials frequently fail to meet recommended reading levels ([19-22](#_ENREF_19)).

Numerous studies demonstrate patient dissatisfaction with the common use of jargon and complex medical terms and limited use of communication methods that support improved understanding and confidence to make decisions ([23-27](#_ENREF_23)). Both individuals with low and adequate health literacy levels find written health information confusing or worrying ([28](#_ENREF_28)). Individuals with inadequate health literacy are more likely to report poor communication in terms of general clarity and explanation of conditions and processes of care ([29](#_ENREF_29)). Few studies have explored the area of health literacy qualitatively ([28](#_ENREF_28), [30-33](#_ENREF_30)) and there are no studies exploring health literacy in the context of falls prevention in older adults. This paper reports on an interview study aiming to explore the views and experiences of older adults with varying health literacy levels attending a falls clinic about their overall experience and views about access to the service and patient-provider interaction.

# Methods

## Study design

To better understand the experiences and attitudes of the participants, semi-structured qualitative interviews were used. This method provided a flexible structure and enabled the researcher (CBr) to build rapport and elicit rich data ([34](#_ENREF_34)). The interviews were analysed using Interpretative Phenomenological Analysis (IPA) ([35](#_ENREF_35)). IPA aims to provide insights into how an individual makes sense of a phenomenon or experience in a given context. As Smith ([36](#_ENREF_36)) describes, the three main characteristics of IPA are idiographic, inductive and interrogative. Idiographic analysis involves a detailed exploration of one case until some degree of closure is reached, before moving onto the next. Inductive analysis aims to allow themes to emerge from the raw data, rather than through reliance on pre-existing literature or theories. Finally, interrogating the data in a detailed and idiographic manner adds important and insightful contributions to the existing literature.

## Participants

Participants with both low and adequate health literacy levels were recruited to this study from one falls clinic in the South of England. This falls prevention service provided rehabilitation services and focussed on self-management. Participants were included if they were aged 65 and above, community-dwelling and had attended the falls clinic in the last three months. Individuals were excluded if they did not speak English as a main language or had severe cognitive, hearing or visual impairments. Staff at the falls clinic identified individuals meeting the inclusion and exclusion criteria. Potential participants were approached after their consultations at the falls clinic and verbal and written explanations of the study were provided to interested participants. The study design and documentation received ethical approval from the NRES Committee South West – Exeter (Reference: 13/SW/0030).

The research was described to participants as a study exploring patients’ views and experiences about attending the falls clinic and provider-patient communication at the falls clinic. This was as opposed to directly using the term ‘health literacy’, which may be a less familiar term for patients and because patients have previously reported feeling shameful about literacy difficulties ([37](#_ENREF_37), [38](#_ENREF_38)). An interview was arranged with consenting participants. Informed consent was obtained by using the ‘teach-back’ method to establish whether the potential participant understood the information provided ([39](#_ENREF_39)). It was anticipated that purposive sampling would be used to recruit individuals with both low and adequate health literacy levels. If after five interviews the researcher recruited participants from only one group (e.g. only participants with high health literacy), a brief validated health literacy self-report measure would be used during recruitment for screening purposes ([40](#_ENREF_40)). However, this strategy was not required due to recruiting participants from both groups. The researcher was aware that both groups were represented resulting from the assessment of participants’ health literacy using the REALM and NVS-UK at the end of the interviews. Due to the depth of analysis and idiographic focus, a small sample size is recommended when using an IPA approach ([35](#_ENREF_35)).

## Data collection

In-depth individual semi-structured interviews were employed to collect data ([41](#_ENREF_41)). Recruitment and data collection took place between the 13th June 2013 and the 6th September 2013. Interviews were conducted in a venue of participants’ own choosing, in all cases in their own homes. Interviews were audio-recorded to allow verbatim transcription. All interviews were conducted by the chief investigator and first author (CBr). CBr was trained in qualitative interviewing and worked clinically within the NHS Trust involved as an occupational therapist, but did not work at the falls clinic involved or have any relationship with the participants or healthcare providers involved prior to the study commencing.

A semi-structured interview guide (Appendix A) was utilised; questions were focussed around participants’ overall experience, access to the service, provider-patient interaction and self-management ([16](#_ENREF_16)). Probes and follow-up questions were used to explore participants’ individual experiences further ([35](#_ENREF_35)). Paasche-Orlow & Wolf’s model and Nutbeam’s framework were used to inform the structure and focus of the interview guide ([16](#_ENREF_16), [18](#_ENREF_18)). The questions were predominantly open and the interview guide was used flexibly, enabling participants to explore areas of interest and importance relating to their personal experience.

After the qualitative interview, the chief investigator (CBr) collected sociodemographic data and measured the participants’ health literacy using the following validated functional health literacy measures:

1. UK version of Newest Vital Sign (NVS-UK) ([42](#_ENREF_42)) – assesses reading, numeracy and comprehension abilities.

2. The shortened version of the Rapid Estimate of Adult Literacy in

Medicine (REALM) ([43](#_ENREF_43)) – assesses medical word recognition.

These instruments were chosen because they are quick and easy to administer ([44](#_ENREF_44)). Care and sensitivity was employed when administering the health literacy measures and levels of health literacy were not checked until after the interview due to potential feelings of shame and anxiety that can be associated with low literacy and disclosure of literacy issues ([38](#_ENREF_38), [45](#_ENREF_45)).

## Data analysis

The data were transcribed by CBr from the audio-recordings verbatim. A transcription protocol was used to ensure that this process was standardised for each transcript ([46](#_ENREF_46)).

The coding process was conducted inductively using QSR NVivo 10 software using the following steps ([35](#_ENREF_35)):

1. Reading and re-reading the transcripts

2. Initial noting

3. Developing emergent themes

4. Searching for connections across emergent themes

5. Moving to the next case

6. Looking for patterns across cases

Two other research team members (JA and CBa) also coded the initial transcripts with CBr to enhance credibility of the findings and researcher reflexivity ([47](#_ENREF_47)).

# Results

## Participant characteristics

Nineteen adults were approached to discuss the study. Nine older adults were interviewed, nine declined participation and one individual was excluded due to severe cognitive impairment. All participants had experienced at least one fall and reported having at least one long-term condition. All participants were white British. Table 1 reveals some discrepancy between the health literacy scores of participants as identified using the REALM when compared with the NVS-UK. All of the participants had low health literacy or a possibility of low health literacy according to the NVS-UK. In contrast, only three participants had low health literacy according to the REALM. In reporting the results the REALM scores have been used, but the different scores are reported in Table 1 along with demographic and clinical data. This issue is also explored further in the Discussion. Demographic and clinical data are shown in Table 1.

**INSERT TABLE 1 HERE**

## 3.2. Main findings

The mean interview length was 43 minutes (range 20 – 87 minutes). Two superordinate themes (building trust, and tailoring communication to individual need) were identified through the analysis. In alignment with the IPA approach, the focus was on themes which were interpreted as having the highest impact on the participants’ individual experiences ([35](#_ENREF_35)). This impact was established through participants’ prolonged attention to these areas and use of language that emphasised their importance ([35](#_ENREF_35)). Quotes which were particularly illuminating are used to illustrate the themes in the following sections.

### 3.2.1. The importance of relationship building and trust when meeting older adults’ health literacy needs

In this research a patient-provider relationship was understood as an ‘interpersonal process that develops over time’ ([48, p.24](#_ENREF_48)). Intrinsically linked to the concept of relationship building is ‘trust’. This research conceptualised trust as having confidence and belief in the reliability, truth, abilities and intentions of another person ([49](#_ENREF_49), [50](#_ENREF_50)). As the excerpts in the following sections illustrate, building relationships with the healthcare providers, auxiliary staff members (e.g. transport and catering staff) and other falls clinic attendees appeared to relax participants, improve their mood and instil in them confidence that staff members were acting in their best interests. These beneficial outcomes seemed to positively affect the participants’ overall experience of attending the falls clinic. Trust and relationships developed may have influenced participants’ motivation to access and be receptive to the service and the healthcare messages delivered within it. This appeared to be important for participants regardless of their assessed health literacy level.

Participants described building positive relationships with both transport and catering staff. For some, this would have been the first face-to-face interaction they experienced with the falls clinic. Some participants discussed in-depth how their time spent on the transport service enhanced their overall experience and reflected on how they went into the falls clinic sessions feeling relaxed and without apprehension. Participant 3 below provides a good example of the interactions and patient responses.

*…some of the drivers are really funny, they’re, they’re well oldish people, you know say in their fifties and er they sing along to the music on the thing, and you’re all sitting there huddled up and everything, and before you know where you are, you’re laughing at them, and then you start talking… and it makes a big, big difference to how you feel (Participant 3, female, age 81).*

Participants also highlighted the relationships they built with catering staff in similar terms. Participant 6 below discussed how the catering staff remembered his favourite dessert; the same participant also valued the transport staff remembering and using his nickname.

*The minute you sit down in there, again I know her very well, the hostess as they call ‘em comes along, ‘would you like a cup of tea? We’ve got so and so, so and so sandwiches, we’ve got two choices of soup’, er… and after a couple of days she’d say, ‘I’ve got your favourite, mince tart with custard’ (laughter) (Participant 6, male, age 80).*

The personable atmosphere created by the transport and catering staff evidently assisted the patients in feeling welcomed and relaxed before their sessions and made the overall experience of attending the falls clinic feel more familiar and less threatening.

Participants were generally very positive about the interpersonal skills of the healthcare providers they had seen at the falls clinic, describing them as ‘friendly’, ‘positive’, ‘humorous’ and ‘attentive’ to their needs. The quote below from Participant 4 provides an example.

***Interviewer: What do you enjoy about going to the falls clinic?***

*Participant: Everything. Meeting the physio, going through the exercises with her, having a laugh with her, she’s very jolly. She makes it fun, we have a laugh over it, and she tells me what she did the night before, her exercise boxing or whatever she does (Participant 4, female, age 75).*

Being recognised as an individual was also important for building relationships with the participants, who discussed valuing written information which recognised them as an individual with personal interests and qualities. For instance, one participant was impressed that his interest in carpentry was mentioned in a GP letter and another was also pleased that he was described as a ‘lovely gentleman’, again in a GP letter. Participants also discussed how building a trusting relationship with the healthcare providers influenced their perceptions about the healthcare messages being delivered. The quote below was from a participant who described initially feeling sceptical about the falls clinic and only believing the health messages after trust was built through confidence in the healthcare provider’s messages and experiential learning. The trust built appears to have impacted on the participant’s willingness to engage with the physiotherapist and her recommendations, in spite of some initial reservations about the physiotherapist’s interpersonal style.

*At the back of my mind… I knew she knew exactly what she was talking about. I think I was bemused that she should speak to me like that. It was almost like going back to school and then… because I’m not you know, I’m not so stubborn, I thought well you know open [your] mind, you know… do what she asks and see. And then… when I realised it worked, then… no problems after that (Participant 8, female, age 84).*

The connection between trust in the physiotherapist and credibility in their communication was a common theme emerging from the interviews.

*She [the physiotherapist] knew what she was talking about. You tell her what was wrong and she knew what you were talking about… and she did something about it… (Participant 3, female, age 81).*

In addition to building relationships with auxiliary staff and healthcare providers, irrespective of their assessed health literacy level, many of the participants discussed how cultivating friendships and interacting with other falls clinic attendees enhanced their experience. This appeared to take place in an unplanned and unstructured manner, such as in the falls clinic waiting room or on the transport service and seemed to be initiated by participants. For most participants this appeared to centre around having company and meeting new people; it did not necessarily involve discussing falls. Some participants also appeared to view this as an opportunity to learn from others. For instance, the participant in the quote below described how important he felt sharing falls-related experiences with other falls clinic attendees was.

***Interviewer: What else do you feel that you’ve learnt?***

*Dylan: I think the most important thing really is people’s personal experiences of… things that might have caused falls… I mean you see the patients come in every day, people you’ve been going with for… 2 months, 3 months (Participant 6, male, age 80).*

### The importance of tailoring education and healthcare to older adults’ health literacy needs and preferences

‘Tailoring’ is defined as adapting and modifying healthcare delivery to meet an individual’s preferences and requirements ([51](#_ENREF_51)). This superordinate theme is closely connected to the first theme of relationship building and trust; in many instances tailored healthcare appeared to support relationship building and the development of trust. Participants felt tailoring of healthcare information to their individual needs was important and discussed aspects of healthcare delivery which did or did not meet their individual preferences and needs. Lack of tailored information appeared to be a barrier and tailored information appeared to be a facilitator to meeting older adults’ health literacy needs.

Participants expressed clear preferences for the tailoring of written information to their individual needs, circumstances and attributes. One participant described a standardised sheet of printed information which was not relevant for each individual’s situation since it did not take into account other health conditions. Participants also wanted personalised discharge summaries and expressed their dissatisfaction with impersonal and overly medicalised letters, as illustrated in the quote below.

*Perhaps I wanted more glowing terms you know. ‘She’s absolutely marvellous’… I don’t know. I really don’t know but I mean she is speaking in medical terms and… maybe I didn’t quite comprehend what she was getting at, I don’t know. I know when I looked at it I thought ooh (laughs) is that all? (Participant 8, female, age 84)*

Some participants appeared to identify preferred learning styles; these translated as experiential learning, observational learning, vicarious learning and reflective learning ([52-54](#_ENREF_52)). Participant 6 (quoted earlier) revealed a preference for learning from others (vicarious learning). Participant 8 below appeared to value reflective learning, but also described needing to try recommendations and see that they worked before accepting them (experiential learning).

*And… although I had the resistance… when I went to the first session… after I got home and sat and thought about it… I could see that that was sense (Participant 8, female, age 84).*

Some participants also reflected polarised opinions on healthcare providers’ use of a direct or authoritarian style of communication, suggesting that healthcare providers should adapt their communication to patients’ preferred styles. This finding revealed no differences according to health literacy level.

Although participants valued the tailoring of information to their individual needs, regardless of their assessed health literacy level, they also appeared to value information being delivered in a clear and simple manner. The quote below illustrates how Participant 6 valued clear and simple communication being delivered ‘without making people feel like idiots’. Clear communication may have also assisted with relationship and trust building here. It is also noteworthy that Participant 6 had higher health literacy according to the REALM, had medical experience through his previous occupations and used complex medical language throughout his interview, yet still valued a simple communication style.

*They always explained everything. Yeah, always explained everything, very well explained in simple form y’know, without making people feel like idiots y’know (Participant 6, male, age 80).*

# Discussion

Understanding the patient perspective and lived experiences of participants through an IPA study provides useful insight for the development of future health literacy interventions. Much of the previously published research on meeting the health literacy needs of older people has focussed on the importance of simplifying and personalising communication. Tailoring communication emerged as a factor in this research, but was inextricably linked to the importance of relationship and trust building as facilitating factors for meeting older adults’ health literacy needs. These factors were revealed as important to participants regardless of their assessed health literacy level.

We found that effective provider-patient interaction is particularly important for older adults in supporting them to access, understand and use information for health. This finding supports the conceptual model developed by [Paasche-Orlow and Wolf (16)](#_ENREF_16) and the view proposed by some health literacy experts and patient participants that health literacy emerges as an interaction between the demands of the health system and the skills of the individual ([31](#_ENREF_31), [33](#_ENREF_33), [55](#_ENREF_55)).

Relationship building and trust emerged as important when older adults were making sense of their experiences of attending the falls clinic. Participants’ level of trust in healthcare providers appeared to be influenced by numerous factors, including whether or not they felt the healthcare provider was knowledgeable, the healthcare providers’ communication abilities and whether they had any success after trying to implement healthcare providers’ suggested strategies. Trust appeared to influence the participants’ readiness to accept and implement the healthcare messages and their motivation to attend the falls clinic. Linking this finding back to Nutbeam’s health literacy definition ([18](#_ENREF_18)), relationship building and trust appeared to influence the participants’ motivation and ability to access, understand and use health information. Additionally, relationship building and trust with auxiliary staff and healthcare providers may be paramount when considering ‘interactive health literacy’. When viewing health literacy as resulting from an interaction between individuals’ abilities and the demands of the healthcare system ([55](#_ENREF_55)), it follows that the interactive abilities of the healthcare providers are also key. Whilst the importance of healthcare providers communicating health information in a comprehensible and accessible manner has been previously documented ([26](#_ENREF_26), [28](#_ENREF_28), [56](#_ENREF_56), [57](#_ENREF_57)), there has been little attention in the literature to the relational aspects of communication when considering health literacy, with health literacy clinical guidance documents not mentioning relationship building or trust ([58](#_ENREF_58), [59](#_ENREF_59)). Additionally, participants in this research appeared to value clear communication regardless of their health literacy level, but the way in which this was delivered was crucial and enhanced relationship building and trust. This supports the view that evidence-based communication strategies should be used with older adults of all health literacy levels ([56](#_ENREF_56), [60](#_ENREF_60)), but that sufficient training should be given to healthcare providers to ensure this is delivered in an effective way. A system-wide approach to health literacy including increased training for all healthcare providers has been recommended as a priority by the All Party Parliamentary Group on Primary Care and Public Health ([61](#_ENREF_61)).

The present research also highlights the importance of tailored communication, therefore ‘universal precautions’ may need to be discussed in terms of using evidence-based communication strategies whilst providing opportunities to extend learning in a tailored manner. Work by Ballinger ([62](#_ENREF_62), [63](#_ENREF_63)) suggested that the disclosure of a fall could be a stigmatising experience for older people, and that as a consequence, ‘Falls’ or ‘Faller’ clinics might prove unpopular. Recommendations by Yardley et al. ([64](#_ENREF_64)) identified ways of mitigating against this and the present research adds that building relationships and trust may be another way of reducing this risk.

The theme about relationship building and trust links the present research to prior research on the importance of trust for optimal healthcare provision, patient satisfaction and adherence to medication or recommendations ([65-67](#_ENREF_65)). Additionally, previous research has revealed patients prefer to receive information in a face-to-face interaction ([28](#_ENREF_28), [68](#_ENREF_68)). This finding also raises important questions about the most effective delivery method of health information to older adults at a time when web-based interventions are increasing.

Perhaps less surprising, the older participants described a preference for information tailored to their individual needs and preferences, including written and verbal information. Patients with both low and adequate health literacy levels have previously expressed frustration at receiving generic information and desire tailored information instead ([68](#_ENREF_68)).

These findings also suggest that tailoring healthcare delivery to older adults’ preferred communication and learning styles may be beneficial when meeting older adults’ health literacy needs. This type of tailoring appears to be more congruent with a more andragogical style of healthcare education ([69](#_ENREF_69)) and in keeping with an ‘asset’ based approach to health literacy ([17](#_ENREF_17)). This shifts healthcare education away from information transmission to proactively engaging patients and aiming to increase autonomy. Many of the older adult participants identified preferred styles of learning, such as observational, reflective, experiential and vicarious ([52](#_ENREF_52), [53](#_ENREF_53)). Previous research has demonstrated that tailoring health information to both literacy level and learning style preferences improves patient understanding of hypertension ([70](#_ENREF_70)). However, this study additionally offers the patient perspective about preferred styles, which has not previously been reported in the literature. Healthcare providers could consider older adults’ preferred learning and communication styles and initiate conversations regarding this, which would enable more personalised tailoring of information. Ensuring information is tailored to an individual and directed towards the patient is consistent with the empowerment principles of health literacy ([71](#_ENREF_71)) and UK NICE guidance ([51](#_ENREF_51)) recommends that healthcare services are tailored to individuals’ needs and preferences.

This study has some limitations. Due to the focus on individual experience and in-depth nature of an IPA approach, a small sample size is advised ([35](#_ENREF_35)). As a result, the findings may not be transferable to other populations. In this study, there were only two males, reflecting less males attending falls prevention programmes and participating in falls research ([72-74](#_ENREF_72)). Future research should include other methods to increase the generalisability.

We also identified problems with the use of established health literacy screening tools with this specific population group. Participants had different health literacy levels depending on the measure used, making it difficult to draw comparisons between individuals with low or adequate health literacy according to the tools used. It is possible that this results from the measures focussing on different components of health literacy. For instance, the REALM focusses on medical word recognition and the NVS-UK primarily focusses on numerical abilities ([75](#_ENREF_75)). Overall, the UK general population has worse numeracy skills than literacy skills ([76](#_ENREF_76)), possibly explaining the discrepancy. Further, numeracy skills may not always be needed for falls prevention activities, justifying the focus on the REALM score for this research.

Finally, the researcher worked in the NHS Trust involved which may have introduced bias. However, a reflexive diary was used, transcripts were independently coded and regular team meetings held to discuss emerging themes. These actions were taken to increase reflexivity, reduce bias and highlight alternative perspectives ([47](#_ENREF_47)).

Despite these limitations, the findings provide valuable insight into the perceptions and experiences of older adults attending falls clinics with varying health literacy levels. The findings provide further evidence that it is important to consider individuals’ abilities and the demands of the healthcare system ([55](#_ENREF_55)), but the research also offered insight into the importance of the quality of the interactions between the healthcare provider and older adult patient, emphasising the importance of relationship-building and trust between the provider and patient. These factors could be considered facilitating factors for creating a positive ‘health literacy environment’, and could be included within checklists which promote the health literacy environment ([77](#_ENREF_77)) and used to develop future models which add to existing health literacy models such as Paasche-Orlow & Wolf’s model ([16](#_ENREF_16)) by highlighting the importance of building relationships and trust and tailoring interactions to patients’ individual needs, such as their learning style preferences. Additionally, to help facilitate healthcare providers’ tailoring of healthcare information, future research could focus on developing a brief tool which healthcare providers could use to ascertain patients’ preferred learning and communication styles. To enable this to be integrated into busy clinical settings, this could be similar to commonly used brief self-report screening tools for identifying health literacy ([40](#_ENREF_40)), but focused instead on the subsequent tailoring of information to individuals’ needs.

Working in the NHS can be busy and pressurised, but small changes could make a substantial difference. Providing more effective and tailored education can both mitigate the risks of low health literacy and aim to develop individuals’ health literacy abilities. Further research is warranted to explore healthcare providers’ views and experiences of meeting health literacy needs and development of health literacy in older adult populations. Exploration of the issue in both younger adults and a healthier younger older adult sample would also be beneficial. The study also suggests more training in understanding health literacy and building trust and a personal relationship with individuals with varying health literacy abilities would be beneficial for healthcare providers and students working towards healthcare qualifications. Health literacy, with a particular focus on tailoring interactions and building relationships and trust, should be integrated into mandatory clinical training programmes and the curricula of all healthcare providers’ degrees.

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# Declaration of interest

The authors report no declarations of interest. All authors have contributed and approved the final article. I confirm all personal identifiers have been removed or disguised so the persons described are not identifiable and cannot be identified through the details of the story. This research was completed as part of requirements for a doctoral award. For the duration of this research, the first author was as a clinical academic doctoral fellow, supported through a collaboration between Solent NHS Trust and the University of Southampton.

**Appendix A. Semi-structured interview schedule**

1. Can you tell me the story of your fall?
   * What happened afterwards?
   * Did you go to hospital?
2. When you were asked to come to the falls clinic, what were your first thoughts?
   * How did you feel about it?
   * What were your expectations?
   * What did you think the purpose of the falls clinic was?
3. Can you tell me about your experience of attending the falls clinic?
   * What did you enjoy?
   * What did you not enjoy?
4. Did you receive any information before you attended the falls clinic?
   * What was this?
   * What were your thoughts about this?
   * What did you expect to get?
5. How did you get to the falls clinic?
   * How was that?
   * What were your thoughts on the directions?
6. Who did you see at the falls clinic?
   * What type of healthcare provider were they? E.g. Nurse, doctor, OT, physio
   * What did you do with them?
   * Can you tell me more about that?
7. What did you think about the communication at the falls clinic?
   * Was any written information provided?
   * What were your thoughts on this?
   * What did you think about the verbal communication?
   * How did that feel?
   * Can you tell me more about that?
8. What did you learn about preventing falls whilst at the falls clinic?
   * What about whilst getting treatment in the community?
   * How did you feel about how that was communicated to you?
9. What decisions were made about your treatment whilst going to the falls clinic?
   * How did you feel?
   * How included did you feel in the decision?
   * What helped you to make that decision / what would help you to make that decision?
10. What was the outcome of your assessment at the falls clinic?
    * How was it given it to you?
11. Were you given any written information to help you prevent future falls?
    * Do you use it?
12. What do you think you can do to reduce your risk of future falls?
    * What might help you to do this?
    * What would prevent you from doing this?

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