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Guidelines on Caring for Individuals With Visual Impairment at the Pharmacy to Promote Inclusive Care: An Interdisciplinary Delphi Consensus

Théodora Merenda | Stéphanie Patris

Unit of Clinical Pharmacy, Faculty of Medicine, Pharmacy, and Biomedical Sciences, University of Mons (UMONS), Mons, Belgium

Correspondence: Théodora Merenda (theodora.merenda@umons.ac.be)

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ABSTRACT

Background: Individuals with visual impairment encounter considerable challenges in managing their treatments, which stem from difficulties in identifying medications, as well as reading and recalling information. Despite the implementation of various management strategies, errors remain prevalent and have the potential to compromise health. Consequently, pragmatic recommendations have been formulated in French for community pharmacists to enhance the quality of care for this vulnerable population.

Aim and Objective: To build an interdisciplinary consensus on guidelines for the care of individuals with visual impairment, with the aim of promoting their inclusion in healthcare.

Method: A consensus-building Delphi survey was conducted between May and October 2024 by a European panel of experts. The interdisciplinary panel consisted of ophthalmologists with a specialisation in low vision, orthoptists, ergotherapists, psychologists, and community pharmacists. The recommendations were encoded in the form of an online questionnaire on the LimeSurvey platform. The experts were invited to indicate their degree of agreement on a nine-point Likert scale. Descriptive statistics were produced using IBM® SPSS 29 Advanced software. This process was repeated until a consensus was reached between all the experts.

Results: A total of four rounds of the Delphi method were required by the panel of ten experts to evaluate the initial set of 32 recommendations. In conclusion, an introduction to the guidelines and 30 recommendations, which have been grouped into six main categories, were validated.

Conclusion: The consensus process has facilitated the consolidation of recommendations and ensured their relevance, thereby enabling the dissemination of high-quality content to French-speaking community pharmacists to support their practice and promote health equity.

1 | Introduction

Visual impairment (VI) is a heterogeneous condition, characterised by its multifaceted aetiology, variable degrees of severity, and diverse rates of progression [1]. Additionally, its association with other disabilities and pathologies further complicates its management and understanding. Court et al. [2] examined the association between VI and the presence of physical conditions (e.g. diabetes or osteoporosis) and mental conditions (e.g. anxiety or dementia) based on patients' medical records. The findings of

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this study demonstrated that 27 out of the 29 physical health conditions and eight mental health conditions analysed exhibited a significantly higher prevalence among individuals living with VI. This emphasises the significance of thorough and frequent medical supervision for such individuals, which should encompass screening for depression [2]. Considering the numerous comorbidities and associated pathologies, individuals living with VI are more likely to require daily medication [3].

Globally, VI has been demonstrated to have a detrimental effect on an individual's capacity to accurately identify medications [4–8], and to understand the information presented on dosage labels [9], patient information leaflets [6], as well as expiry dates [10] and dosages [6, 7, 9, 11]. Indeed, two studies conducted among individuals with VI revealed consistent difficulties in medication management: 75% to 92% of participants were unable to read expiry dates, 58% to 75% could not identify their medications, 82% had problems recognising dosages, and 89% were unable to read dosage labels [9, 10]. A further study by McCann et al. [12] demonstrated that approximately 30% of older individuals with VI require assistance in the management of their medications, despite the utilisation of optical aids. Furthermore, participants with VI reported a range of challenges related to medication use, including heightened anxiety and a need for assistance in accessing medication information [6], frequent forgetfulness in taking medications [11], difficulty locating their medications [5], and problems recalling the instructions provided for their medications [3].

To overcome these difficulties, people living with VI use a variety of strategies. Riewpaiboon et al. [13] have shown how blind people manage their medication. Indeed, 20% of the participants in their study were given medications in packaging that could be distinguished by touch. The participants were able to distinguish the medications, their dosages and times of use, relying mainly on memory. Hearing aids were also used [13]. Other strategies used by these individuals included setting reminders to take medications and organising medications [4, 6, 11], as well as locating medications in different places and recognising the texture of medications or containers [3]. Additionally, they tend to create their own systems using nonvisual techniques, such as identifying a medication by its smell or wrapping a rubber band around similarly shaped bottles [14]. However, these techniques are prone to error and can sometimes lead to taking the wrong medication [15].

Qualitative studies were conducted separately with community pharmacists [16], physicians [17], and people with VI [18]. The data collated in these three studies enabled the identification of the needs and expectations of individuals with VI and pharmacists, the elements taken into consideration by physicians, and potential solutions for improving care. Based on these preliminary studies [16–18], 32 recommendations were developed, incorporating select elements from a comprehensive review of the extant literature to broaden their scope. The aim of these guidelines is to enhance the access to health information and ensure the safe use of medications for individuals with VI.

The objective of the present study was to establish an interdisciplinary consensus on guidelines to provide French-speaking community pharmacists with consolidated content and thus promote the inclusion of all persons with VI in healthcare.

2 | Methods

The recommendations were evaluated by a European interdisciplinary panel of experts using the Delphi method. This technique is frequently employed to obtain an in-depth assessment of a given subject without direct communication [19, 20], and is well-established for the development of guidelines in the pharmaceutical field [21]. The reporting of this paper follows the guidelines for the Conducting and REporting of DElphi Studies (CREDES) [22].

2.1 | Questionnaire

A questionnaire comprising 32 recommendations written in French was encoded online on the LimeSurvey® platform. The questionnaire was divided into six categories (Table 1). Each question corresponded to a recommendation and included only one idea to facilitate the Delphi process.

All the initial recommendations ($n = 32$) are available in the supplementary material (Appendix 1).

2.2 | Experts' Selection Criteria and Recruitment

To contribute in an optimal manner to the validation process, the selection of experts required them to demonstrate

TABLE 1 | Categories of recommendations before the Delphi process ($n = 6$).

Categories and names		Number of R (*n = 32*)
Category 1	Access to the pharmacy for individuals with VI	7
Category 2	Guide dog	2
Category 3	Identification of individuals with VI	3
Category 4	Communication with individuals with VI	8
Category 5	Pharmaceutical care for individuals with VI	10
Category 6	Administration to third parties (*example: a mother with VI who must administer medication to her child*)	2

Abbreviations: R, recommendation; VI, visual impairment.

competence in the field under study [23, 24]. Therefore, the experts included in the study were required to possess comprehensive knowledge of low vision and experience working with individuals living with VI, or a comprehensive understanding of pharmaceutical care. Participants were considered experts based on objective criteria, including their professional roles (e.g., pharmacists, rehabilitation specialists) and their direct experience with individuals with VI, either in community pharmacies or specialised rehabilitation centres. Although they were not formally designated by an external organisation, their daily practice and responsibilities provided them with relevant and practical expertise, consistent with the principles of Delphi methodology. Any experts who did not have expertise in these domains, who were not fluent in French, and who had one or more conflicts of interest were excluded from the study.

Experts were recruited on a voluntary basis in Belgium and France. Telephonic contact was initiated with community pharmacists and low vision professionals operating within a functional rehabilitation centre to present the study. Subsequently, a comprehensive informational letter was disseminated via email to the professionals who had expressed their interest in participating in the study.

2.3 | Data Collection

The link to the questionnaire, as well as the original version of the recommendations, were dispatched separately to each expert via e-mail [25, 26]. An explanatory note was provided, reminding experts of the purpose of the validation and the time limit set for the completion, to ensure that experts could provide the most optimal answers [27]. The distribution of weekly reminders to the experts was utilised for the completion of the questionnaire. The experts were invited to indicate their level of agreement with each recommendation on a nine-point Likert scale (1 = total disagreement, 9 = total agreement) [28], and to provide a justification for a score of less than 7 so that the recommendations could be modified in the most appropriate way [29]. Participants were permitted to make a single attempt. After the conclusion of each Delphi round, a thorough analysis of the results was conducted, any necessary modifications were implemented, and a new questionnaire was encoded and transmitted to the experts. The results of the preceding rounds were also communicated to the experts [25]. This iterative process was continued until a consensus was reached between the experts on all the recommendations [26, 30, 31].

2.4 | Data Analysis

Descriptive statistical analyses were performed. The 25th percentile (Q1), median (Q2), and 75th percentile (Q3) were calculated for each recommendation using the IBM® SPSS 27 software [25]. Furthermore, the percentage of scores falling within the intervals [Q1; Q3] and [median − 1; median + 1] was calculated for each recommendation. The validation of a recommendation was determined by the attainment of a score falling within the intervals [Q1; Q3] and [median −1; median +1], with a minimum threshold of 70% [30]. Recommendations that were not validated, modified, or commented on were resubmitted for evaluation in subsequent rounds.

2.5 | Ethical Considerations

After the completion of the questionnaire by the experts, the data remained non-anonymised for the researchers. This approach was adopted to facilitate direct communication with the experts via telephone if a misunderstanding persisted despite the provided commentary [30]. Nevertheless, to ensure the anonymity of the participants, e-mails were disseminated to each expert individually. Upon analysis of the results, a code comprising a letter and a number was assigned to each expert, for example E1 meaning “Expert 1”. This enabled the results of preceding rounds to be communicated in a pseudonymous manner.

3 | Results

The Delphi process was conducted over a 6-month period, from May to October 2024. A panel of ten experts, comprising 10% men and 90% woman with an average experience of (18 ± 8) years, was initially constituted for this study. Table 2 presents the sociodemographic characteristics of the sample.

A total of four rounds of the Delphi method were required to achieve consensus and thus validate the recommendations. Figure 1 provides a description of the Delphi validation process.

Round 1: The ten experts who were contacted completed the questionnaire in full. A total of 32 recommendations were submitted for evaluation. Nine recommendations were considered as validated, and 20 recommendations underwent modification based on the experts' comments. An introduction to the recommendations, along with two additional recommendations, were incorporated. Three recommendations were also removed, as they were deemed to be irrelevant by the majority of the subject experts.

Round 2: The questionnaire was distributed to the ten experts, and nine complete responses were received. The tenth expert never replied to the various reminder e-mails and was therefore considered to have abandoned the participation. A total of 22 recommendations and one introduction to the recommendations were submitted for evaluation. The introduction to the recommendations and 12 of the recommendations were considered as validated, nine recommendations underwent modification based on the experts' comments, and one recommendation was removed.

Round 3: The nine experts who were contacted completed the questionnaire in full. A total of nine recommendations were submitted for evaluation. Seven recommendations were considered as validated. The subsequent two recommendations underwent modification based on the experts' comments.

Round 4: The nine experts who were contacted completed the questionnaire in full. Following the conclusion of the present round, the two recommendations submitted for evaluation were considered as validated.

TABLE 2 | Sociodemographic characteristics of the sample.

Experts	Gender	Profession	Province/region	Experience (years)
E1	F	Psychologist	Brabant wallon	28
E2	F	Ergotherapist/orthoptist	Brabant wallon	30
E3	F	Community pharmacist	Namur	18
E4	F	Psychologist	Hainaut	14
E5	H	Community pharmacist	Hainaut	8
E6	F	Ergotherapist	Hainaut	21
E7	F	Ophthalmologist	Hainaut	15
E8	F	Ophthalmologist	Île de France	21
E9	F	Ergotherapist	Brabant wallon	3
E10	F	Orthoptist	Île de France	20

Abbreviations: M, man; W, woman.

Upon completion of the four validation rounds, the European interdisciplinary panel of experts validated an introduction to the recommendations and 30 recommendations, which were grouped into six categories (Table 3).

All the validated recommendations ($n = 30$) are available in the supplementary material (Appendix 2).

4 | Discussion

4.1 | Contribution of the Validation Process

To assist healthcare professionals in ensuring the safety of medication treatments for individuals with VI, the development of recommendations appears to be imperative. The guidelines on caring individuals with VI at the pharmacy are the culmination of a systematic process of reflection and drafting, exclusively based on data gathered from community pharmacists, physicians, and persons with VI in semi-structured interviews [16–18]. Nevertheless, the dissemination and implementation of recommendations represent two significant stages in the process. Indeed, as emphasised by some authors, the importance of implementation strategies as the 'how to' component of changing healthcare practices is paramount [32]. Implementation strategies are recognised as necessary to realise the public health benefits of evidence-based care [33] and are composed of specific means or methods for adopting and sustaining interventions [34]. These strategies include, among others, training healthcare professionals to help them understand and use the recommendations, regular reminders, and frequent updates of the recommendations to promote adherence [32]. Ongoing education and regular reminders therefore, appear to be effective strategies for the long-term use of recommendations. Moreover, the utilisation of recommendations by healthcare professionals constitutes a pivotal component of this approach. The term 'appropriation' is employed to denote the process by which healthcare professionals comprehend and assimilate the recommendations, to the extent that they are convinced of their usefulness and simplicity, thus enabling effective application in their clinical practice. However, it is possible that some elements may be erroneous or incomplete. Consequently, a rigorous validation process is essential before the broader dissemination of these guidelines.

The Delphi method is designed to identify consensual proposals around a given concept [29]. During this study, 30 recommendations received such approval. The experts emphasised the necessity of adapting the recommendations to specific constraints present in the field, including spatial limitations, the configuration of pharmacies, and the heterogeneity of individuals living with VI. The necessity to eschew overly general or intrusive measures was emphasised, with the objective of averting the stigmatisation of patients. The preference for a personalised approach, predicated on dialogue and consent, was also underscored. Finally, it was highlighted that certain recommendations are not specific to individuals with VI and must be considered in the broader context of universal accessibility and common sense.

4.2 | Clinical Approach

The recommendations have been formulated with the intention of guiding pharmacists in adapting medication management to individuals living with VI. It is therefore imperative that pharmacists first identify patients with VI and adapt their communication accordingly. The subsequent step is to determine the patient's preferences and needs. In addition, the complexity of the treatment must be evaluated, as well as the actions that are necessary to ensure the safe administration of medication. To implement the aforementioned recommendations in clinical practice and to provide specific pharmaceutical care, three aspects must be given full consideration: (1) the attitudes of healthcare professionals (in this case, pharmacists), (2) the patient characteristics, including their level of autonomy, visual residual, and reading ability, and (3) the treatment characteristics, including the chronic or acute nature of the treatment, the presence of polypharmacy, the need to use a medication plan, the presence of dosage forms not suitable for pill organisers (*e.g.* a syrup), and the need to use medical parameters measurement devices (blood pressure monitor, glucometer, thermometer). The pharmacist is then able to cross-reference

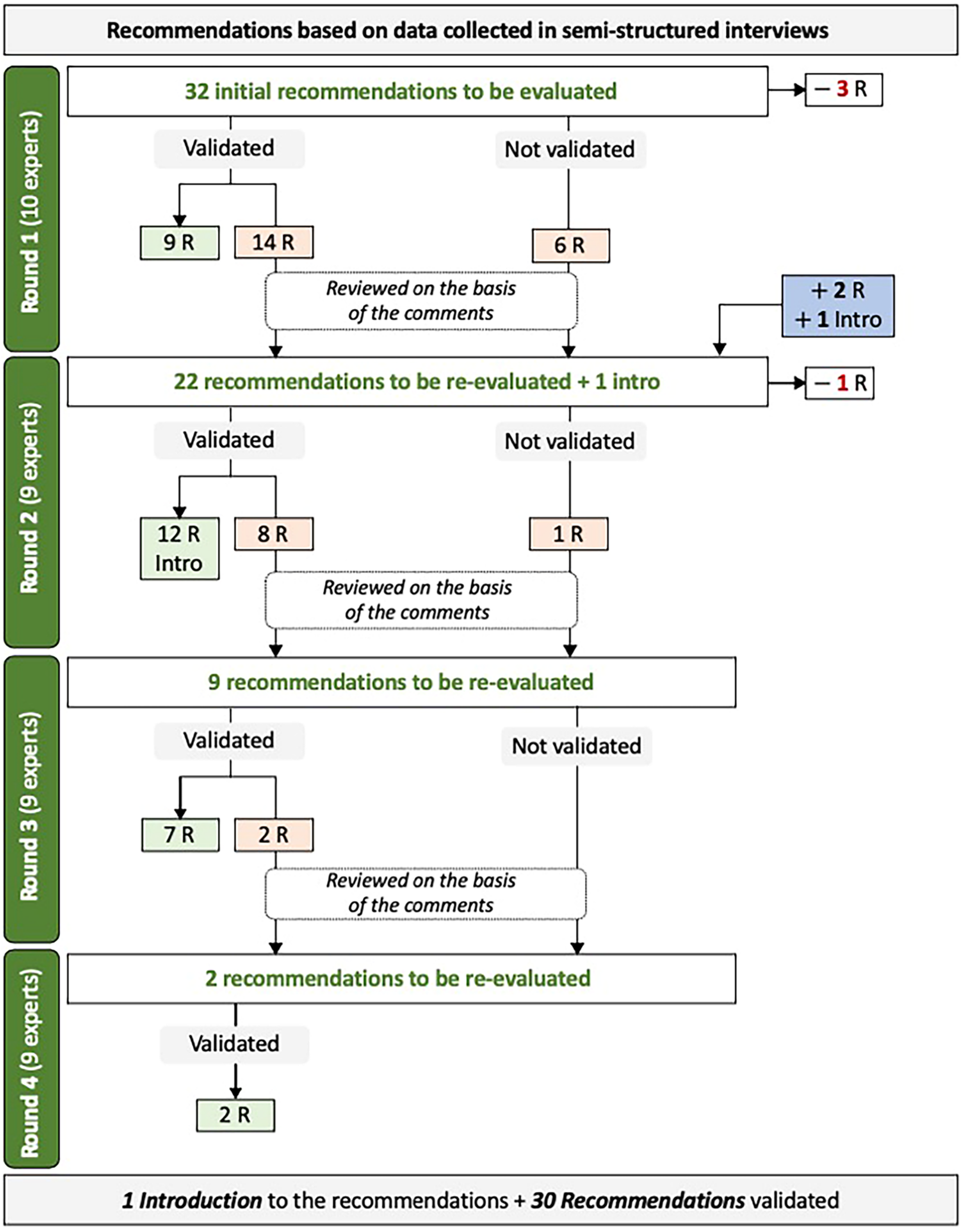

FIGURE 1 | Process for validating recommendations using the Delphi method. Recommendations designated as "to be reassessed" corresponded to recommendations that had been modified or not validated. R: recommendation.

the various recommendations to select the most suitable pharmaceutical care for the patient's specific circumstances. In this context, the establishment of a multidisciplinary care network around these patients is essential. Ideally, patients should be referred to ergotherapists to obtain and be trained in the use of assistive products, or to orthoptists for optimal reading parameters. To obtain further information regarding visual abilities, it would be advisable to collaborate with ophthalmologists. As illustrated in Figure 2, a five-step decision tree is provided to assist pharmacists in implementing these recommendations.

4.3 | Strengths and Weaknesses

The present study is notable for several strengths. The collective knowledge of the interdisciplinary experts facilitated a thorough examination of subjects pertaining to pharmaceutical care and VI. The sociodemographic data indicate that over half of the experts had over a decade of experience, demonstrating a profound understanding of the subject matter. The recruitment procedures also stipulated the solicitation of low vision experts from Functional Rehabilitation Centres located in Belgium and France. Consequently, the panel of experts was geographically well represented, and the multicentric approach helped to improve the statistical robustness of the results by eliminating recruitment bias. Furthermore, each profession was adequately represented on the panel (two experts per profession) to avoid over-representation of any one profession and thus avoid bias during the validation process. The Delphi method has been shown to offer the advantage of anonymising the results for the experts, thereby enabling each expert to express their opinion freely without the influence of dominant opinions within the group [35]. The online completion of questionnaires obviated

TABLE 3 | Categories of recommendations after the Delphi process.

Categories and names ($n = 6$)		Number of R ($n = 30$)	Explanation
Introduction to the recommendations		—	This introduction highlights the significance of adapting certain general practices to patients in fragile situations, particularly those living with VI. It emphasises the necessity of instilling a sense of awareness within the pharmacy team to circumvent any potential stigmatisation and to cultivate an approach that is predicated on the authentic and articulated requirements of the patient.
Category 1	Access to the pharmacy for individuals with VI	1	This category aims to improve the physical and spatial accessibility of pharmacies for individuals with VI through design, signage, and support. It proposes concrete adaptations to facilitate orientation, circulation, and reception of these patients.
Category 2	Guide dog	1	This category focuses on the appropriate attitude to adopt when the patient with VI is accompanied by a guide dog.
Category 3	Identification of individuals with VI	2	This category emphasises the imperative to interrogate patients or their proxies to discern any difficulties or vulnerabilities, thereby ensuring the identification of the needs and preferences of individuals with VI. Examples of questions are also provided.
Category 4	Communication with individuals with VI	8	The present category is concerned with the significance of efficacious communication and the presentation of recommendations for the enhancement of communication between patients with VI and community pharmacists.
Category 5	Pharmaceutical care for individuals with VI	10	This category provides a plethora of advice to pharmacists on how to enhance the management of individuals with VI. The advice encompasse strategies, such as facilitating the location and the identification of medications, modifying dosage labels and information materials, and proposing personalised follow-up measures and interventions.
Category 6	Administration to third parties (*example: a mother with VI who must administer medication to her child*)	2	This category encompasses advice on the facilitation of medication administration to third parties, in addition to the pharmacist's capacity to conduct personalised training with the individual responsible for treatment administration, within a confidential framework and with adequate support time.

Abbreviations: R, recommendation; VI, visual impairment.

the necessity for the experts to convene in person, a particularly advantageous feature given the geographical dispersion of the experts. Furthermore, questions for which consensus had been reached in preceding rounds underwent modification based on the comments provided and continued to be evaluated in subsequent rounds. This development resulted in enhanced relevance and clarity of the recommendations, accompanied by a discernible shift from a low to a moderate overall consensus.

Nevertheless, it is important to acknowledge the limitations of this study. Despite the panel of experts comprising the number of members recommended in the literature (10 to 15 experts) [28, 30], one expert withdrew from the study during its course. This can be attributed to the considerable number of rounds and the extensive time commitment, which may have resulted in a certain degree of weariness. Indeed, the Delphi method necessitates a considerable investment of time and effort from

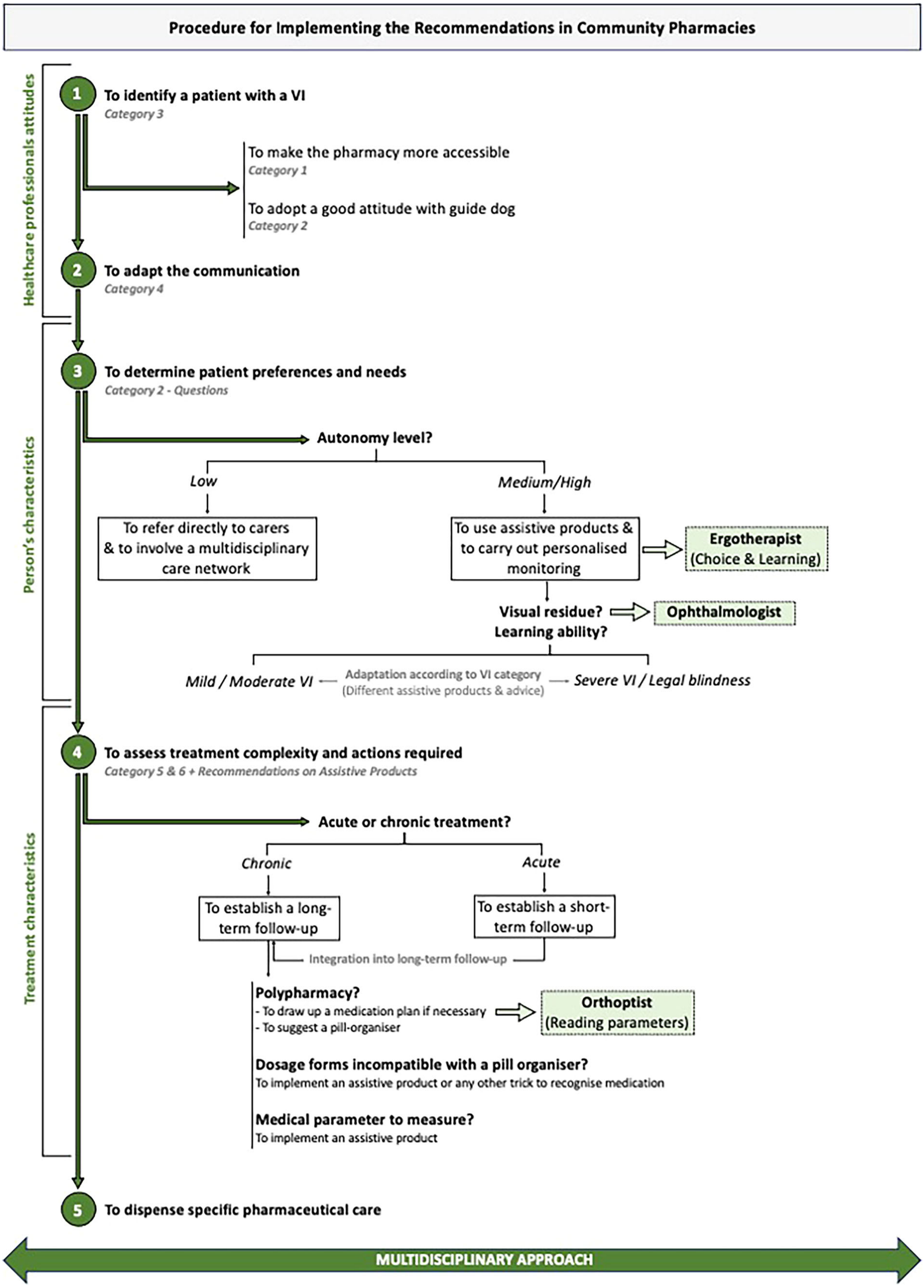

FIGURE 2 | Procedure for implementing recommendations in community pharmacy practice in five steps. VI: visual impairment.

both researchers and participants, which can lead to attrition [36]. It is also important to acknowledge that the duration of the process may have introduced a degree of bias in the responses when the questionnaires were completed. Additionally, the data analysis process intrinsic to the Delphi method is subjective. The process of condensing, refining, and developing recommendations is subject to the knowledge, experience, and perceptions of the researchers [37]. During the study, the researchers sought to integrate the comments of the panellists in a manner that was both suitable and indicative of their input during the subsequent formulation of recommendations.

While this Delphi study aimed to establish expert consensus on best practices, we acknowledge that it does not include outcome measures or implementation data. The recommendations presented here serve as a foundational framework for improving clinical practice, but further research is needed to evaluate their feasibility, acceptability, and impact in real-world settings. Future studies should explore how these practices can be operationalised across diverse clinical environments, considering contextual constraints and resource availability. This would help bridge the gap between consensus-based guidance and practical application, ultimately enhancing patient safety and care quality.

5 | Conclusion

The Delphi method was employed to elicit crucial information from experts regarding the qualitative content of the recommendations drafted in French. This consensus process facilitated the consolidation of recommendations and ensured their relevance and consistency with the issues addressed. The dissemination of high-quality content on caring for individuals with visual impairment to French-speaking community pharmacists has the potential to facilitate their safe use of medications. However, individuals with visual impairment constitute a heterogeneous group. The presence of such diversity can be attributed to a variety of factors, including the nature of the visual impairment, the time of onset, and the concomitant presence of other disabilities or pathologies. Additionally, the development of specific recommendations, tools, and training for each type of disability represents a significant challenge for healthcare professionals, thereby complicating the implementation of such initiatives. It is therefore imperative to achieve a balance between the development of general approaches to inclusion and the consideration of the specific needs associated with each type of disability to facilitate the task of healthcare professionals and guarantee the sustainability of the services offered. This would ensure universal accessibility to healthcare, with optimal, personalised, and equitable care for all patients, while alleviating the workload of healthcare professionals. Consequently, concerted efforts between researchers, healthcare professionals, and people with disabilities are still required to develop inclusive and effective training, recommendations, and tools.

Author Contributions

Théodora Merenda: conceptualisation, methodology, formal analysis, investigation, writing – original draft. **Stéphanie Patris:** conceptualisation, validation, writing – review and editing.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available in the supplementary material of this article.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.
Appendix 1. Appendix 2.