

Management of Long Term Care In Era Covid-19

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1. Abstract

COVID-19 gives the chance to address long-term care categories that are sometimes disregarded and undervalued, such as nursing and residential homes, as well as homecare. Each method of delivering long-term care must meet the highest possible standards of ongoing care and quality of life. More study and evaluation are needed to aid decision-making and policy-making, particularly on the cost-effectiveness and cost-quality elements for each country, region, or system. So far, data suggests that person- and relationship-centered solutions, paired with coordinated health and social care, as well as telehealth, are effective in ensuring fast, personalised answers to people. There are common principles to consider regardless of the situation (private home or nursing home). The fundamental pillars of a new long-term care model are supported by a variety of evidence-based and policy publications. The choices of older people, as well as their active participation and those of their caretakers, must be the starting point. Combined health and social care must be modeled in this manner, with disability prevention and rehabilitation as unifying goals. Continuity of care by qualified experts on a frequent basis should have been combined with primary care facilities. Geriatrics and gerontology specialists should be included in both the conceptual and management elements, as well as receiving healthcare in cases of severe healthcare requires and specialized time-limited treatments at home during health emergencies. Every older person requires a customized care pathway and an enhanced care plan based on a full geriatric assessment, patient care principles, and a shared decision-making approach at the individual level. Contributions in specialized training to increase patient outcomes, as well as developing and evaluating care standards, are critical on a structural level. Telemedicine solu-

tions are beneficial in terms of continuing education, consulting, assistance, and benchmarking. Prototype direction and development will, without a doubt, be shaped by realistic economic and financial aspects for each setting. The danger is that management determines based on absolute costs within a narrow paradigm, such as reducing hospitalizations or readmissions, rather than on value-based evaluations or decisions (cost-quality or whole system impact). Furthermore, if these options are not designed at a system level and given at a reasonable cost, differences in older people's socioeconomic status will grow. Moreover, other variables will impact the overall model, such as the role of informal care, which is extremely context and culture-specific.

2. Covid-19 Monitoring and Long Term Care

Coronavirus diseases's (COVID-19) outbreaks have been reported in long-term care institutions around the world, ranging from nursing homes to rehabilitation clinics [1]. Long-term care patients (or residents) require continual care, live in close quarters, and are typically older and multimorbid, putting them at a higher risk of getting SARS-CoV-2 (the virus) and suffering significant COVID-19 (the disease) consequences [2,3]. Healthcare workers are also susceptible to infection, and in the absence of proper cleanliness and infection-prevention measures, they can spread the virus to patients and coworkers [1,4]. Despite the fact that the full scope of the current pandemic remains unclear and ever-evolving, long-term care institutions have and continue to have a higher burden of SARS-CoV-2 infection and COVID [5]. COVID-19 surveillance is crucial for early epidemic diagnosis and the creation of appropriate public health interventions to minimize spread, such as patient isolation, contact tracking, and better infection prevention [6]. The reverse transcriptase polymerase chain reaction (RT-PCR), which

is typically done on clinical samples from nasopharyngeal swabs, is the most recent gold-standard diagnostic method [7]. Despite its sensitivity and specificity, RT-PCR is extremely expensive, must be outsourced for organizations lacking on-site personnel, and is frequently subject to shortages and severe usage rules. Symptomatic infections, on the other hand, are simply the tip of the iceberg: numerous illnesses can cause no or only minor symptoms, produce vast amounts of virus in the absence of symptoms, and take a long time to heal [8]. COVID-19 outbreaks are thought to be caused by silent spread from asymptomatic and presymptomatic illnesses [8], getting the virus into healthcare organizations unknowingly and triggering nosocomial spread [8]. Inappropriate surveillance systems, as well as those without testing capabilities or relying simply on symptoms as signs for testing, have been reported as aggravating factors for COVID-19 outbreaks in long-term care institutions [1]. Several surveillance approaches have been proposed to maximize testing while accounting for the specific transmission dynamics of SARS-CoV-2, including randomly testing healthcare personnel, screening all patients upon admission, and universal or serial testing [9]. COVID-19 surveillance is limited in practice due to limited testing capability and health-economic resources, particularly in low- and middle-income countries [9]. Community testing (sample pooling, which mixes clinical specimens from multiple persons into a single biological sample for a single RT-PCR test) has gained favor as a therapeutically responsive and resource-efficient alternative to individual-based testing due to research shortages [10]. COVID-19 monitoring in long-term care settings must be adjusted to decrease and dissuade possible nosocomial outbreaks, taking into account both the epidemiological features of SARS-CoV-2 and the limited availability of testing techniques.

3. Frailty, Long Term Care and Covid-19

Frailty is a symptom of older people's health and functioning problems, and it makes them more vulnerable to negative health consequences. During COVID-19, certain studies will focus on the individual's relationship with their family and carers, as well as organizations, society, and specific policy decisions that affect older persons' vulnerability [11-13]. The following examples demonstrate this flaw: a) visitor limits limit communication options for families and caregivers; b) people living in rural quarters and insufficient staffing services lead to administrative insecurity among residents; c) on a local level, staff contact with residents, particularly in relation to transportation, may raise the risk of infection. COVID-19 is a human-infecting virus; d) on a more general level, there is support for services and monitoring barriers, i.e., testing barriers can lead to a reduction in incidence and mortality as a result of COVID-19 being discovered [14,15]. Previous research has shown that the clinical frailty scale (CFS) should be used to discern anomalies in state of health and conditions, vaccine efficacy (as seen during influenza season), and unusual disease ex-

pression in underdiagnosed circumstances (as seen in infections in long-term care facilities) [16,17]. Several research have looked into the use of such biomarkers in measuring clinical symptoms in COVID-19 aged persons. In order to understand why older people's immune responses assist (or hinder) their ability to resist disease, researchers are still looking for biomarkers and immune system assessments. They include biomarkers for inflammation, systemic inflammation, mitochondrial and apoptotic induction, calcium homeostasis, fibrosis, muscular activity, sarcopenia, bone/hormone metabolism, and nutritional status [18,19]. For example, while it is generally known that standard influenza vaccines do not provide adequate protection for the elderly, it is less well known that frailty is a strong indication of vaccine efficacy against influenza - hospitalization as a result of the incident [20]. Despite this, there has been little research on the association between frailty and immune biomarkers of vaccination programs, influenza disease [21,22], or other respiratory diseases such COVID-19 [23]. By assessing cytokine levels in the plasma or serum, infectious diseases such as SARS-CoV-1, pandemic influenza (H1N1), and COVID-19 have provided crucial insights into disease intensity [24]. IL-6 levels are frequently used to identify patients who should be treated with IL-6 receptor blockers [25]. IL-6 levels have been used to select individuals for IL-6 receptor blockers, and high levels of IL-6 are a biomarker for severe infections such influenza and COVID-19 [25]. The significance of biomarkers stems from the fact that 1) biomarkers, in combination with physical examination, may be useful in identifying people at high risk for serious COVID-19 infection, 2) biomarkers may be used to categorize patients into care groups, and 3) biomarkers may reveal valuable information about the pathways of serious illness. Then there's the question of why frailty affects illness appearance and recovery, as well as whether healthy people and elderly susceptible long-term care facility patients have different immune systems. As a result, it's critical that aged frail individuals be included in study so that findings from healthy people aren't applied to the elderly, frailer, and more vulnerable population. Furthermore, there are few studies looking into the relationship between frailty, biomarkers, and the severity of disease in older persons. Biomarkers can help identify high-risk individuals, classify patients into care groups, and provide further information on the origins of hazardous infections. Monitoring and more research on fragile inhabitants may provide insight into how COVID-19 affects high-risk and vulnerable persons, enabling for more effective COVID-19 public health interventions.

4. Diabetes Management and Long Term Care During Covid-19

The prevalence, severity, and mortality of Covid-19 appear to be trending toward the elderly, particularly those with concomitant comorbidities such as diabetes, obesity, hypertension, and cardiovascular disease [26]. In fact, this would make providing effective

diabetes treatment in national diabetic programs around the world extremely challenging [27]. The number of people diagnosed with diabetes has doubled in the last decade and is continuing to rise [28]. Type 2 diabetes develops when the pancreas stops making adequate insulin to meet the body's needs or when the body fails to respond to the insulin generated [29]. As a result, if cells are unable to use glucose, it can build up to dangerous amounts in the blood, harming organs and tissues. Diabetes is a disease that affects many organs, including the skin, kidneys, nerves, heart, and circulatory system. High blood glucose levels can damage the heart, leading to heart disease and other complications. Incontinence, an increased risk of infection, sluggish recovery, and confusion are some of the other negative consequences of persistently high blood sugar in the elderly [30]. Diabetes has been linked to a variety of conditions, including schizophrenia, dementia, dental problems, hepatitis B and C, and hypothyroidism. Patients with Type 2 diabetes must monitor their blood glucose levels, lose or maintain a healthy body weight, and avoid complications. In the city, there are diabetes education facilities that provide customers with a team approach to education and care. Clients are taught how to keep track of their own health at home, including how to perform blood sugar tests and manage their symptoms. Diabetic patients in long-term care facilities can benefit from a range of services. Residents in long-term care facilities may be physically frail, have other clinical diagnoses, have cognitive or emotional disabilities, and be on a variety of drugs. They are unable to manage their diabetes on their own and require in-home care from medical professionals. Hospital services, meals/snacks, games, and prescriptions are all customized to each resident's hazards, impairments, and needs. Although frailty and other health issues can make strict adherence to norms designed for younger or more autonomous adults problematic, each resident's unique situation is considered [31]. To improve their quality of life, these gaps in meeting the needs of the elderly exist: In every way possible, people must feel comfortable and healthy. Several senior homes are employing a "liberalized diet" plan for diabetes patients, encouraging them to eat the same foods as everyone else [32]. This improves their quality of life, and studies have shown that a less restrictive diet leads to greater meal satisfaction with less restrictions, as well as increased nutritional consumption for overall better health. Blood sugar levels in long-term care residents are also monitored as needed to better regulation. Long-term care professionals are aware that in order to lessen the danger of low blood sugar, "normal" blood sugar levels for the elderly should be higher [32]. Nutritionists in long-term care track residents' progress toward their goals, such as monitoring blood glucose levels and developing personalized food plans for community members with uncontrolled blood glucose levels or who require a special diet due to diabetes complications such as end-stage renal disease, dialysis, or other health issues. Residents are evaluated and tracked quarterly, or more frequently as needed,

by nutritionists, nurses, and other health care practitioners, who develop care plans to address their individual health and medical needs. Low blood glucose, or hypoglycemia, can be dangerous for the elderly. Seniors who are frail are more likely to be unaware of hypoglycemia symptoms. This disorder is known as "hypoglycemia unawareness." Low blood sugar can cause trembling, sweating, headaches, weariness, disorientation, confusion, and fainting, which can all lead to falls, concussions, or broken bones. These can be serious and life-threatening complications for the elderly, so it's critical to avoid blood sugar levels from falling too low. Hypoglycemia should be treated at home according to current guidelines. Diabetes management in long-term care institutions entails facility workers doing most self-care duties on behalf of residents. The use of a realistic diabetes management model in long-term care institutions will also help staff education and diabetes management [33]. As a result, patients in long-term care facilities have the right to the finest therapy possible. It's crucial to think about seniors as people rather than as a group because their needs, interests, and levels of physical and mental health are all distinct. When a multidisciplinary team in a long-term care facility works together to guarantee a diabetes patient's highest possible quality of life, including blood sugar monitoring and management, optimal care is provided.

5. Alzheimer's Disease, Long Term Care and Covid-19

In long-term care and community-based settings, emergency events, such as the current COVID-19 epidemic, present particular challenges to Alzheimer's disease (AD) and dementia. COVID-19 infection may be more common in patients with AD and dementia-related risk factors [34]. Patients receiving treatment or utilizing resources in these settings are more vulnerable to challenges due to their age and other medical conditions. Staff can be affected by an emergency as well. Due to anticipated staffing shortages, it may be difficult to keep operations functioning during a pandemic, epidemic, or tragedy. At this point, non-clinical workers may be used to assist with treatment. It is vital to exchange information on individuals with Alzheimer's disease with the staff in order to provide excellent, consistent, and appropriate treatment. Because the care team may move often during a pandemic or crisis, briefing sessions at the start of each shift will allow workers to share critical details about patients who require treatment [35]. Patients in long-term care and community-based AD and/or dementia care may need help interacting with their relatives and loved ones during a crisis. Caregivers can utilize a variety of strategies to keep family and friends updated, including: a) staying in touch by scheduling phone or video calls, and/or encouraging family and friends to send letters and photos [36]; b) providing information on where and how family members can get updates or communicate with a caregiver about a loved one who has AD [37]; c) ensuring that adaptive technology, including as cochlear implants and eye-

wear, are available to users at no cost when they are needed [38]. Keep in mind that each family is unique. Friends or members of the community, rather than biological or legal family members, may be the most effective advocates for some patients. It is vital for individuals with Alzheimer's disease to maintain their strength, especially when they are at risk of contracting a virus. Patients with eating and drinking disorders could benefit from a variety of treatments, including: a) staff becoming familiar with the person's eating and drinking habits as well as their ability; because he or she will be unable to detect hunger or hydration, he or she will need to be motivated or pressed to drink and eat [39]; b) behaviours that are verbal, visual, or tactile, such as high contrast dinnerware, adaptive utensils, graduated procedures, and mirroring behavior, can encourage people to eat and drink [39]; c) sitting and conversing with a dementia patient at regular intervals can encourage them to eat more [40]. Any indicators of difficulty swallowing should be checked by a skilled healthcare professional [41]. All Alzheimer's patients who have been diagnosed with a risk of suffocation or a predisposition to have trouble swallowing should be supported and monitored by trained personnel. Walking is a high-intensity exercise that increases flexibility and independence [42]. Unsafe wandering occurs when an Alzheimer's patient wanders off, causes havoc in banned situations, or escapes a secure area [43]. When a patient is dissatisfied, furious, or faced with stressful circumstances, the likelihood of unsafe roaming increases, which is especially true in emergency situations. If non-pharmacological measures are ineffective after being used on a regular basis and patients with AD have major illnesses or the potential to damage themselves or others, medicines may be advised [44]. If the pharmaceutical regimen or the person's health changes, the need for therapeutic intervention should be reevaluated. You should advise visitors to make adequate considerations and need safety precautions while visiting care facilities, such as: a) those who have not been vaccinated may consider being examined before arriving; the facility should also limit the number of unvaccinated visitors at any given time; b) guests should be limited to approved sites only, with no access to other parts of the community; visitors should keep as far away from other residents as possible; c) to limit the danger of transmission, consultations should be done outside whenever possible; d) if visitors develop a fever or symptoms consistent with COVID-19 within 14 days of their visit, they should contact professionals; e) visitors should bring their own face mask to the facility, put it on before entering, and keep it on at all times; masks should fit snugly over the mouth and nose and be securely fastened; f) provide guests with access to a handwashing sink if at all practicable. If hand washing is not possible, give and advocate the use of an alcohol-based disinfectant containing at least 60% alcohol. Finally, we believe that vaccines are an important step in protecting the health and safety of residents and personnel in long-term care in-

stitutions, and we strongly encourage their use.

6. Malnutrition, Long-Term Care and Covid-19.

Coronavirus disease 2019 (COVID-19), caused by the severe acute respiratory syndrome coronavirus-2, initially appeared in China in December 2019 and has since spread around the world [45]. It can proceed to pneumonia, which warrants hospitalization, or to severe acute respiratory distress syndrome, which necessitates ICU therapy [46]. Malnutrition is a common complication of viral respiratory illnesses, and it can worsen the outcome [47]. According to study, almost half of COVID-19 patients exhibit dysfunction of the gustatory and olfactory nerves [48]. As a result of these illnesses, nutritional intakes may be lowered. Malnutrition was found to increase the chance of prolonged hospitalization in COVID-19 disease patients who would have received particular care and precautions throughout clinical treatments, according to Yu et al. [49]. The findings suggest that nutritional support therapy should be started as soon as possible in patients with nutritional risk or malnutrition [49]. The European Society for Clinical Nutrition and Metabolism (ESPEN) wants to provide thorough nutritional treatment recommendations for COVID-19 patients by publishing ten practical guidelines [50]. The practical advice is directed at individuals who work in intensive care units (ICUs), as well as those who are older or have polymorbidity, all of which are associated to malnutrition and its negative impact on patient survival [50]. Despite this, only a little amount of information on the prevalence of malnutrition in COVID-19 patients has been gathered to yet. The COVID-19 pandemic has wreaked havoc on the elderly. In fact, some studies will focus on the individual's interaction with their families and carers, as well as institutions, communities, and specific policy decisions that affect the vulnerability of older persons [1,2]. Official statistics are likely undercounting virus-related deaths since total deaths include an approximation of the whole COVID-19 effect [3]. Between countries, the mortality burden and the accuracy of the tallies varied greatly [3]. Acute respiratory distress syndrome (ARDS) is frequent in COVID-19 hospitalized patients. These individuals are sick for a long time and have a high metabolic rate. Malnutrition is, for the most part, an illness that may be avoided. When left untreated, it has a negative impact on one's health and finances. Malnutrition has a particularly negative impact on the elderly. Several elderly people are either at danger of malnutrition or are already malnourished [51]. Hospitalizations for protein-calorie malnutrition are five times more likely to be fatal, and the elderly have significantly higher diagnostic rates [52]. It's also associated to more expensive medical expenditures and longer hospital stays [52]. Typical aging symptoms such as loss of appetite, difficulty chewing or swallowing, the use of multiple medicines, and neurocognitive impairment can all affect diet and nutrition. Because to chronic sickness, cancer, accidents, and hospitalization, elderly individuals are at danger of malnutrition.

Medical situations requiring surgery or intensive care, as well as chronic conditions such as cancer, diabetes, and gastrointestinal, lung, and heart problems, as well as their therapies, can cause nutritional changes that contribute to malnutrition. Poverty and unemployment are two key social factors of the risk of malnutrition, while pandemic security measures like as stay-at-home orders contribute to social exclusion and limited food access [53]. Malnutrition is associated with COVID-19 disease, and disease-related malnutrition puts immunocompromised patients at risk of catching the virus. Symptoms such as fever, cough, shortness of breath, muscular discomfort, disorientation, headache, sore throat, chest pain, pneumonia, diarrhea, nausea and vomiting, and loss of taste and smell are common in these people, all of which can impact nutrition and immune function [54]. These indications and symptoms restrict food intake and put you at risk for malnutrition. It's common knowledge that poor nutrition and sarcopenia are linked to advancing age and the occurrence of comorbid illnesses [55]. In COVID-19, a high BMI appears to be connected to poor outcomes, suggesting that sarcopenic obesity is a factor [56]. Finally, COVID-19 and malnutrition are also concerns for the elderly. These conditions are linked to unfavorable consequences and can intensify one another. Nutritional screening, diagnostic, and therapy actions can help COVID-19 patients.

7. Vitamin D Supplementation and Long Term Care During Covid-19

Coronavirus disease 2019 (COVID-19) outbreaks have been reported in nursing homes, rehabilitation clinics, and other long-term care institutions around the world [1]. Long-term care patients (or residents) who require constant care, live in close quarters, and are often elderly and multimorbid are more likely to develop SARS-CoV-2 (the virus) and have severe COVID-19 effects [2,3]. SARS-CoV-2 sensitivity and disease development have been associated to vitamin D deficiency [57]. Educational services, nutritionists, and other doctors may be able to extend this information to social media health platforms and forums used by adults for specific vitamin D-containing nutrients, ensuring that what people have been exposed to is science-based and provides for particularly feasible, safe, and low-cost solutions and activities, particularly during the winter months [58]. Vitamin D insufficiency is common among patients in long-term care facilities. Skin exposure to the sun is required for endogenous vitamin D synthesis, which is in limited supply for most people in long-term care institutions. Despite the fact that vitamin D is available in small levels in some foods, preventing vitamin D deficiency without dietary supplementation is challenging in the absence of enough sun exposure [59]. It could also cause muscle tiredness and an increased risk of falling [60]. Due to the ambiguous signs of vitamin D deficiency, either screening or frequent supplementation is required. There isn't enough evidence to suggest that everyone in a nursing home be evaluated for vitamin D insufficiency. Serum 25-hydroxyvitamin D is the single

best test for detecting whether a patient is vitamin D deficient. Despite the relatively high frequency of vitamin D deficiency in this population and the relatively low cost of the test, frequent vitamin D supplementation should be recommended for all nursing home patients [61]. A serum 25-hydroxyvitamin D level, parathyroid hormone level, and calcium level really should be considered during the assessment of individuals newly diagnosed with osteoporosis [61]. These tests aren't required before beginning a regular vitamin D supplementation regimen. Supplementing with vitamin D is not advised for persons who have hypercalcemia or show indicators of vitamin D toxicity. People who are hypersensitive to any element in a vitamin D-containing product should avoid using vitamin D supplements. Phenobarbital and phenytoin diminish plasma levels of 25-hydroxyvitamin D by blocking vitamin D 25-hydroxylase activity in the liver. In this case, it's unknown what form of treatment will be most effective. COVID-19 infection has a higher disease incidence and fatality rate among the elderly and chronically ill individuals, who are at a higher risk of vitamin D insufficiency. Vitamin D also helps with inflammation and immunological function [62]. Vitamin D supplements come in two forms: vitamin D2 (ergocalciferol) and vitamin D3 (cholecalciferol) (cholecalciferol). Cholecalciferol, a natural form of vitamin D, is present in nature. A typical daily dose ranges from 200 to 400 IU (5-10 micrograms). Calcium and vitamin D are frequently combined in a single tablet. Depending on the source, the amount of vitamin D that should be taken as a dietary supplement varies. At a minimum, 400 IU should be administered successfully, while 800-1000 IU is a superior dosage for elderly nursing home residents. 400 IU of Vitamin D per day has been demonstrated to be insufficient in preventing fractures in elderly persons [63]. Given the significant mortality and disability associated with hip fractures in this population, as well as the low cost and side effects of supplementation, this is a reasonable measure. Vitamin D is not included in sufficient amounts in all multivitamins. The amount of vitamin D in a multivitamin should be considered when calculating the dosage of supplemental vitamin D. Overdoing it on vitamin D can lead to nephrocalcinosis. Some long-term care residents receiving a blend of calcium and vitamin D may not be able to endure this treatment due to irreversible constipation harm caused by the calcium. In conclusion, a daily calcium intake of 1200 mg is recommended for elderly individuals in long-term care, and vitamin D administration should be continued if calcium treatment is discontinued.

8. Discussion

Several possibilities have arisen as a result of the pandemic for nursing home (NH) staff and clinicians to consolidate and develop on resident management practices in order to both avoid and improve COVID-19 instances. Because all residents are at risk and asymptomatic infections are widespread, the techniques apply to all residents, regardless of whether they have a known COVID-19 infection. Nursing staff, the only professional care workforce

among NH employees, played a critical role in supplying registered nurse care and skills for residents' physical and psychological needs, as well as satisfying the requirements of high-risk elderly people with chronic diseases during the COVID-19 outbreak [64]. Unfocused information consists of text generated via digital platforms has a very large effect on the current economy and society, therefore studies to create potential using social big data have subsequently been done [65]. Appropriate sampling literature reviews collect data through restricted topics and testing, which presents challenges in terms of verifying the reliability and validity of the examined data from numerous perspectives. Social big data, on the other hand, gives a significantly larger volume of data from a variety of people [66], making it more precise to determine public's opinion. As a result, using social big data to detect customers' healthcare service demands is simple [67]. It is critical to understand consumers' views and needs in order to represent their requirements in clinical services [68]. In the post-coronavirus era, research has been carried on legislation and government initiatives for the use of big data, evaluation of the highly specialised rehabilitation treatment health coverage fee, and death rates for residents with dementia, all of which have used the big data prototype in the hospital setting [69]. Given the financial benefits and legal advice, NHs have been under mounting pressure to limit hospital transfers during the last decade. Even during pandemic, reducing needless transfers is particularly necessary because they expose susceptible NH residents to hospital-acquired diseases as well as the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Utilizing techniques and warning systems to detect improvement or deterioration slightly earlier, organized interactions with healthcare practitioners (HCP) in the NH and between the NH and the hospital, including the use of methodologies to determine when a clinician should be informed rapidly about a particular change in condition are all examples of these schemes. Good teamwork and cooperation with local hospitals and health systems, as well as a review of interfacility transfer regulations and initiatives to educate nurses, advanced practice clinicians, and clinicians, can help to reduce transfers. Participating in advance care planning talks with all residents and their families, as well as amending advance directives as needed, can help guide decision-making on the appropriateness of hospital transfers. This is particularly critical in cases involving intensive care unit beds and respirators [70]. In NHs, pharmacological treatments and the prescriptions of possibly ineffective drugs are prevalent. Because decreasing drugs can indeed minimize adverse reactions and save money, but it can also minimize the danger of viral transmission and the requirement of personal protective equipment (PPE) by minimizing nurse-resident interactions, and it could save nursing time when many NHs are short-staffed. There are numerous evidence-based and expert-recommended techniques available to assist reduce polypharmacy, needless drugs, adverse events, and the

amount of nursing time required to monitor various indicators (eg, sliding scale insulin, overtreatment of hypertension and hold parameters) [71]. Infection management relies on minimizing individual attention between HCP and residents, which defends both residents and HCP. Residents should undergo an assessment aimed at decreasing the quantity of medications and the frequency with which they are administered, and medical personnel should collaborate with the consultant pharmacist. Eliminating unneeded drugs, as indicated above, and maximizing the use of long-acting treatments rather than multiple dosage short-acting medications are two particular treatment objectives. If necessary, consider stopping certain treatments for a few weeks or months and then restarting when the infection risk is lower. Vitamins, unused PRN (as needed) meds, continued probiotic usage, and treatments with no demonstrated benefit in NH residents with advanced diseases and/or severe dementia, such as lipid-lowering therapies and cholinesterase inhibitors, are examples [72,73]. Because of the danger of viral transmission during these operations, measures to minimize and/or discontinue any aerosolizing procedure (e.g., continuous positive airway pressure [CPAP]/bilevel positive airway pressure [BPAP]/nebulized drugs) should be carefully examined. If there is an infection inside this facility and/or limited PPE, multiple clinical interactions can be effectively restricted or temporarily suspended for a few extended periods of time to reduce resident contact. Once enough vaccines have been administered to lessen the pandemic's dangers, a clear strategy is necessary for continuing any such care or treatment. The virus heightens the urgency of completing and documenting consent forms in terms of improving end-of-life care. Some inhabitants of New Hampshire have advanced illnesses, and many are nearing the end of their lives. They may quickly worsen with respiratory distress if they contract the virus and develop COVID-19 symptoms. Transferring to the hospital and receiving respiratory care in the intensive care unit may be needlessly taxing for these patients and their families. During the COVID-19 pandemic, normal immunization guidelines for NH residents should remain unchanged. Moreover, when it comes to COVID-19 vaccination, the timing of normal vaccinations may be taken into account. This is covered in greater depth elsewhere. Patients should be vaccinated against influenza as soon as possible by NHs. Unless there is a clear contraindication, all employees should undergo influenza vaccine. Staff immunity is a key role in keeping the sickness from spreading among New Hampshire people, many of whom do not have a strong immune response to the vaccine. In people with acute COVID-19, therefore, vaccination should be deferred until the acute disease has passed, as with other acute infections. The Centers for Disease Control and Prevention (CDC) encourage this strategy in their influenza vaccine advice, and it is appropriate to apply this idea to other routine immunizations [74]. The probability of an escalation in resident mortality should be factored into NH plans. Ensure that enough morphine and seda-

tives are available for residents with agitation and dyspnea, as well as for terminal patients for those facing death; contact frequently with family of residents nearing death who are unable to be available at the bedside. With the assistance of staff, residents should be capable of making phone and video calls to their loved ones. The guidelines for end-of-life visits should be understood by families. Residents nearing the end of their life are offered palliative care consultations or, if available, hospice services. Residents, relatives, and HCP can get social and spiritual support from the hospice care staff. Hospice can also help loved ones cope with the loss of a loved one. However, given the restrictions on visiting, the function of nursing agencies may be difficult. Palliative care consultations can be conducted electronically, and surrogate decision-makers and loved ones are frequently involved. Palliative care experts can help with symptom management as well as advance care planning talks. Other resources for virtual palliative care end-of-life visits can be found here. End-of-life care, particularly care for isolated residents, is covered elsewhere. Modifications to terminal management for COVID-19 patients are covered separately. Several of the techniques listed above, which are intended to limit resident interaction with other residents, their families, and HCP, have an impact on the physical and psychological health of all residents. To strike a compromise between the need to preserve residents from infection and the danger of isolation-related morbidity, NHs would remain to even provide direct contact for residents and restart family visitation as soon as possible, when permitted [75]. A more in-depth look at the psychological effects of quarantine can be found elsewhere.

9. Conclusion

COVID-19 gives the chance to address long-term care categories that are sometimes disregarded and undervalued, such as nursing and residential homes, as well as homecare. Each method of delivering long-term care must meet the highest possible standards of ongoing care and quality of life. More study and evaluation are needed to aid decision-making and policy-making, particularly on the cost-effectiveness and cost-quality elements for each country, region, or system. So far, data suggests that person- and relationship-centered solutions, paired with coordinated health and social care, as well as telehealth, are effective in ensuring fast, personalised answers to people. There are common principles to consider regardless of the situation (private home or nursing home). The fundamental pillars of a new long-term care model are supported by a variety of evidence-based and policy publications. The choices of older people, as well as their active participation and those of their caretakers, must be the starting point. Combined health and social care must be modeled in this manner, with disability prevention and rehabilitation as unifying goals. Continuity of care by qualified experts on a frequent basis should have been combined with primary care facilities. Geriatrics and gerontology specialists should be included in both the conceptual and management ele-

ments, as well as receiving healthcare in cases of severe healthcare requires and specialized time-limited treatments at home during health emergencies. Every older person requires a customized care pathway and an enhanced care plan based on a full geriatric assessment, patient care principles, and a shared decision-making approach at the individual level. Contributions in specialized training to increase patient outcomes, as well as developing and evaluating care standards, are critical on a structural level. Telemedicine solutions are beneficial in terms of continuing education, consulting, assistance, and benchmarking. Prototype direction and development will, without a doubt, be shaped by realistic economic and financial aspects for each setting. The danger is that management determines based on absolute costs within a narrow paradigm, such as reducing hospitalizations or readmissions, rather than on value-based evaluations or decisions (cost-quality or whole system impact). Furthermore, if these options are not designed at a system level and given at a reasonable cost, differences in older people's socioeconomic status will grow. Moreover, other variables will impact the overall model, such as the role of informal care, which is extremely context and culture-specific.

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