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INTRA-NORMATIVITIES IN TECHNOLOGIZING OLD AGE CARE WORK: MOBILE RECORD-KEEPING, REMOTE HOMECARE AND SOCIAL MEDIA USE SHAPING GOOD CARE

Eveliina Saari
Finnish Institute of Occupational Health
Finland
ORCID 0000-0003-4710-8011

Vilja Levonius
Finnish Institute of Occupational Health
Finland
ORCID 0000-0001-5672-8939

Inka Koskela
Finnish Institute of Occupational Health
Finland
ORCID 0000-0002-9315-7060

Tiina Koivisto
Finnish Institute of Occupational Health
Finland
ORCID 0009-0001-9830-9502

Marja Känsälä
Finnish Institute of Occupational Health
Finland
ORCID 0000-0003-1460-6049

Abstract: *Western societies tend to implement new technologies to old age care work to replace routines in order to make services more efficient and transparent as the population ages and public resources diminish. However, we have not paid enough attention to how care practitioners perceive their changed circumstances in old age care work. Drawing on the thematic interviews of 31 care practitioners in Finland, we analyzed how the emergence of mobile record-keeping during homecare visits, use of video visits in remote homecare and social media use in intensive service housing shaped what is perceived as good care. Leaning on empirical ethics of care approach we found that each old age care service context and its technology shape its own intra-normativities. Each intra-normativity brings different values into being in old age care, which impact on work practices and how the relations between care practitioners and clients, and with the wider public are enacted.*

Keywords: *old age care work, ethics of care, socio-materialism, technologization, intra-normativity.*

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INTRODUCTION

Western societies are currently facing a care crisis because of an aging population structure and diminishing public resources. As aging significantly increases the use of social and health care services in societies, politicians are searching for means to make old age care services more efficient (Kröger, 2019). The current political and academic remedies for the care crisis, particularly in Northern countries, are mainly technological in nature. They suggest digitalization, technological efficiency, surveillance, and AI-based algorithms as solutions to the care crisis. This reduces the phenomena to an economic and technological problem (Kovalainen, 2021). However, previous case studies of care work (Bergschöld, 2018; Ertner, 2019; Tufte, 2013; Hyysalo, 2004; Frennert & Östlund, 2018) have shown that efficiency is not easily achieved by implementing new technologies. The use and implementation of technologies in care work has created new tasks for care practitioners who are already strained (Kröger, Aerschot, Puthenparambil, 2018). Furthermore, the standardized logic of organizing work tasks guided by enterprise resource planning systems in each care practitioner's mobile phone has been seen as contradicting the situational logic of reacting to each client's individual and unique needs (Eskelinen, 2017).

Low-paid care practitioners are often excluded from technology implementation decisions but remain involved in the utilization network, which make their client relationships more technology mediated (Hyysalo, 2004). The introduction of technology in care contexts has raised worries about altering care practitioners' occupational identity (Ajslev, Højbjerg, Andersen, M., Andersen, L., & Poulsen, 2019). Core care values, including responsiveness and engagement with clients' needs, emphasized by care ethicists (Waerness, 1984; Tronto, 1993), might be reshaped by technology integration, impacting care practitioners' subjectivity (Halford, Obstfelder, & Lotherington, 2010). Research has highlighted concerns related to technology use in the context of caring for vulnerable older individuals (Hämäläinen 2020; Frennert 2023; Persson, Redmalm, & Iversen, 2022). The impact of technology on essential aspects of care, such as the professional–client relationship, physical presence, and empathetic engagement (Hämäläinen 2020), has not been extensively and empirically explored.

In our study, we lean on the research approach of *empirical ethics of care* (Mol, Moser, & Pols, 2010; Pols, 2015), which enables us to analyze how care practitioners actually shape goodness in their daily work and form new intra-normativities within care practice. It challenges care ethicists' understanding of care in its idealistic form (e.g., Tronto, 1993; Fineman, 2004; Gilligan, 1982) and unfolds care as socio-materialistic activity confined and enhanced by variety of contextual, technological, and social relations in which care is enacted. Performing good work is not necessarily the same as giving good care, thus we focus on finding variations in care practices in the care practitioners' talk, depending on how the care was organized and what kind of technologies were in use. As older adults' capabilities and work contexts vary in different old age care services, the conditions for providing good and empathic care to the clients might differ significantly. To be able to understand the variety of technological contexts we focus particularly on how mobile record-keeping in homecare, video appointments via remote homecare, and the use of social media as part of care work in intensive service housing (ISH) shape how the care practitioners consider their practices aiming at good care. The following research question lead our

empirical research: *How the technologies mentioned above shape care practices in such a way that they form intra-normativities what is considered good care from the care practitioners' perspectives?* For providing a solid theoretical point of departure, we explain in the next section the difference between care ethicists' and socio-materialistic approaches in understanding good care.

Good Care: From Care Ethics to Empirical Ethics of Care

According to care ethics theorists (e.g., Tronto, 1993; Fineman, 2004; Gilligan, 1982) caring is a social practice involving one subject encountering another and responding to their needs and abilities. Caring refers to reproductive labor that fulfills the needs necessary for individual survival, development, and social reproduction (Engster, 2005, p.51). Care ethics theorists also claim that caring aims to transform social relations by preventing dependency or force from distorting them, through three virtues: attentiveness, responsiveness, and respect (Noddings, 2013). According to Carol Gilligan (1982), being attentive in care means that everyone should have a voice and should be respectfully listened to and carefully heard on their own terms. Good care involves responsiveness, which refers to engaging in some form of dialogue with the client in order to discern their needs and monitor their responses to care (Engster, 2005). Responsiveness to a need may relieve suffering and pain, so that the care recipient may live their life as well as possible and function as well as possible in society. Respect as a virtue of caring derives from not treating clients as lesser beings because they have needs, they cannot meet themselves (Engster, 2005, p.55).

Care ethicists see the relational interdependence of people as a source of wellbeing (Pols, 2015). The idea of relational care challenges the prevailing principles of medical ethics, which is dominated by the idea of patient autonomy: the patient is a subject who exists and acts all by themselves (Kohlen, 2009). Seeing care as relational seems to be a cornerstone of old age care philosophies. For example, in person-centered dementia care, memory loss among older adults is not merely treated as a disease; strengthening the client's social contacts and their belonging to society has been particularly valued as a way of helping them maintain their identity and self for as long as possible (Fazio, Pace, Flinner, & Kallmyer, 2018). Personhood is dependent on other people, so finding ways to maintain selfhood through interactions and conversations is seen as fundamental in caring for people with dementia.

Care ethicists see empathy being at the center of good care. They consider empathy as a relational phenomenon, instead of reducing it to a personal quality, trait or capacity that can be individually measured and learned. The relationality of empathy means that it is seen as a co-creative practice involving the participation of both the care practitioner and the care receiver (Van Dijke, van Nistelrooij, Bos, & Duyndam, 2020). Empathy has been defined as a unique way of connecting with others and being able to feel the same emotions as another person, which is essential for motivation to care and for moral reflection (Slote, 2007; Hamington, 2017; Meyers, 1994). It is fundamentally other-directed, thus from the care practitioner's perspective, it requires allowing oneself to be affected by the care recipient, by listening more than asking, allowing the care recipient to lead them (Noddings, 2013).

However, old age care circumstances are rapidly changing, and technologies are transforming care relationships, and thus the normative definition of care ethics what good

care is about, has been considered too rigid and static by the research approach of *empirical ethics of care* (Mol et al., 2010; Pols, 2015). The problem of defining virtues of attentiveness, responsiveness, and respect as criteria for good care is that they are normative, and position care practices in a world of facts, with moral values added from the outside (Pols, 2015). Empirical ethics of care as a socio-material research approach defines care as the task of arranging, modulating, and resolving social bonds. Ethics comes not only from outside care, but also from within care practices, placing *intra-normativity* at the center of analyses. It is based on the relationality of things such as technologies, activities, and words, constructing relations between people. The empirical ethics of care does not suggest that the intra-normativities in care practices are necessarily good but sees them as practices in concrete historical situations that can be compared and questioned, even learnt from (Pols, 2015.) Good care can be empirically researched by analyzing how care practitioners strive in local and material circumstances to deliver good care as interrelational achievement of people. Normativity appears thus in different old age care services in different forms, when care practitioners' attempt to put something good into practice. Each practice embeds a different notion of what is good care (Pols, 2015), therefore values, that are brought into being, can be identified from the concrete situational care practice and its explanation.

Related Research: Old Age Care as Socio-Material Practice

Based on the socio-material approach to care, Annemarie Mol, Igunn Moser and Jeanette Pols (2010) have argued that care practitioners and technologies entail each other in practice. Technologies do not work or fail in of themselves, instead they depend on care work and on the practitioners' willingness to adapt their tools, but also adapt their care to the tools, endlessly tinkering (Mol et al., 2010). Here we highlight the findings of socio-material studies, which have been focused to practices of care practitioners in homecare, remote homecare, and intensive service housing. The technologies used differ and the capabilities of older adults vary in different old age care services, and this shapes care practices.

A dominating technology in homecare visits during the last decade in Finland has been electronic patient records on the clients' state of health, which the care practitioner must enter on their mobile device, as well as enterprise resource planning systems that optimize the time spent with each client. Mobile record-keeping has become the practice during daily homecare visits. It is expected to reduce errors and improve coordination between professionals (Hämäläinen & Hirvonen, 2020). However, it has been experienced to distract the attention of the care practitioners when they interact with the clients (Hämäläinen, 2022; Koskela, Känsälä & Saari, 2023). In previous studies, particularly temporal structuring embedded in enterprise resource planning systems, appearing as optimized homecare visits, have been observed to limit the care practitioner's flexibility when encountering the various situational needs of their clients. This has been resulting as neglection of the emotional dimensions of care (Dyck & England, 2012; Tufte, 2013), or even change how care practitioners experience themselves as competent professionals, considering skillful timesaving as a modern competence in caring (Bergshöld, 2018). The practice-based study of Finnish homecare practitioners (Koskela et al., 2023) analyzed the practices of balancing good care and the time-saving logic of the mobile technology. Five different strategies for combining mobile documenting and good care were found: 1) multitasking, 2) pausing interaction with the

client, 3) recording without the client noticing, 4) double recording using a memo or a piece of paper, and 5) moving the recording task outside the client visit. Balancing good care and scheduled visits was described as a tension and was managed during the work shift by 1) being flexible with client visiting times, 2) limiting tasks or speeding up work, 3) moving tasks outside normal working hours, and 4) self-regulating time-related experiences and emotions.

Introducing telecare devices, such as home-based video-conferencing tablets, has been often justified by efficiency gains, as tasks are delegated from care practitioners to clients and aging-in-place is enabled (Pols, 2010; Mort, Finch, & May, 2009). Telecare technology has been observed to shift the responsibility of health monitoring to the patients and altering the care dynamics by establishing a physical distance in a care relationship that previously involved direct physical touch (Oudshoorn, 2012; Cartwright, 2000). From the socio-material perspective, telecare technologies have not been seen as universally good or bad solutions, but rather as situated solutions, depending on the installation practices, the context of the users and care relations (Mort et al. 2009; Sánchez-Criado, López, Roberts, & Domènech, 2014). However, in terms of experiencing empathy and ethics as an essential part of care, telecare has been coercive: Older people have been monitored by devices at home, and their opportunities for residential care or physical homecare have diminished (Mort, Roberts & Callén, 2013).

Care activities in ISH consist of body work, involving direct contact with the body of the client: touching, lifting, washing them, and so on. As well as being responsible for using assistive technologies to help move residents from beds to communal areas, for example, care practitioners are responsible for arranging meaningful social activities for the residents (Theurer et al., 2015). The newest technology in use in old age care is social media (Rantala, Taipale, Oinas, & Karhinen, 2022), such as Twitter, YouTube or Facebook, either as an inspiration for social events or for documenting daily events for the public. We wanted to delve into effects of this newest layer of technology, because as far as we know, the use of social media as part of old age care work has not yet been qualitatively studied (Levonius & Sivunen, 2024). However, Nordic local authorities have harnessed social media to connect with citizens and stakeholders, enhancing transparency, accountability, and trust (Xu, 2020). Twitter (from 2023 Twitter is called X) is a prominent platform for sharing work-related content (Van Zoonen, Verhoeven, & Vliegenthart, 2016), influencing the professional identities of those practicing "working out loud" (Sergi & Bonneau, 2016). This is particularly relevant in the context of care work, in which the blending of conventional face-to-face interactions and modern online engagement shapes a diverse and dynamic professional identity (Levonius & Sivunen, 2024).

DATA AND METHOD

The analysis is qualitative multiple case study, in which the formation of intra-normativities in old age care work are interpreted in their socio-material contexts. It aims to understand how good care can be enacted and ensured, as each old age care work context has different relationships with the prevailing technology. It focuses on how mobile record-keeping in homecare, video

visits in remote homecare and the use of social media as part of care work in ISH form new intra-normativities what is considered good care.

The analysis was based on a dataset of audio-recorded and transcribed interviews, conducted in Finland, in two municipal organizations that provided homecare and two private organizations that provided around-the-clock service housing, ISH. The interviews were conducted between January and June 2021. Ten supervisors or managers were interviewed from ISH and seven from the homecare units. These interviews were used as material to describe the work contexts of the different services. The analysis of the care practitioners' experiences was based on 12 interviews in homecare, five interviews in remote homecare, and 14 interviews in ISH. Of the 31 care practitioners interviewed, 24 were practical nurses and 7 were nurses. The care practitioners were interviewed near their own work premises and the supervisors and managers were interviewed via Teams. All the interviews lasted between 60 and 80 minutes. The interviews were conducted in pairs, so that the first author participated in all the interviews and the rest of the authors each participated in the interviews in one particular research site.

The study was conducted in accordance with good ethical research norms. The research plan and data collection procedures were approved by the Ethics Committee of Finnish Institute of Occupational Health (October 9th, 2020), and all the participating organizations gave their permission for the research to be conducted. Informed, written consent was obtained from all the interviewees, who were advised that they could withdraw this consent at any point during the study. All names and other details that could enable identification of the participants were removed or altered in the text and data excerpts. We selected the interviewees from voluntary persons, taking care to include care practitioners with both little and expansive work experience, varying degrees of familiarity with using technology, and different educational backgrounds (practical nurses and nurses) in the sample.

The interview themes included descriptions of work history, changes at work and technology-mediated communication, use of social media, technological knowhow and agency, relationships with clients, understanding empathy and good care, well-being at work, and future work prospects. In this article, we focus on analyzing the empathy and good care theme, and its relation to other themes of the interviews.

The first phase of the empirical analysis was inductive and was conducted as pair work. The second and third author first coded the homecare and remote homecare interview texts into four categories: 1. Expression of empathy or empathic practice in care work: These texts discussed routines and habits, and the ways in which the care practitioners aimed at good care in their work. 2. Good care: These texts discussed the definition of good care, caring, and empathy. 3. Significance of care: These texts discussed the importance of empathy in care work. 4. Being able to experience empathy in everyday work: These texts discussed the factors that promoted or hindered feeling empathy and forming empathic relationships with clients. Using the same categories, the first and the fourth author then coded the interview data from the ISH. In the first coding phase the Atlas.ti program was used.

The first category (expression of empathy or empathic practice in care work) became the largest, and the content of its excerpts was the richest and most diverse. Therefore, we selected it for deeper analysis. Five categories were then constructed from these excerpts which reflected the social circumstances and habits of enacting and creating good care: 1. Creating circumstances for empathy, 2. Sharing emotions and touching clients gently, 3.

Encountering clients as human beings, 4. Learning from the client, and 5. Promoting social inclusion and a good life.

After the content analysis, based on categorization and splitting the data into small analysis units, the first author read the interviews as entire texts, one service context at a time. This second phase of the analysis was the contextual narrative analysis (Denzin, 1997, p. 231–249), in which the story of each interview in its old age care context was interpreted. The findings were partly written based on the preliminary categorization, and partly as a way to help us understand how the socio-material context and use of technology shaped good care. We focused on how the care practitioners' relationships with technologies and clients constructed their practices of good care in the interview narratives, thus resulting as identifying typical intra-normativities in each old age care context. For the analysis of the intra-normativity, we interpreted the values that were brought into being in the context- and technology specific care practices, which the care practitioners had described in the interviews. This interpretation phase was inspired by Jeanette Pols (2015, p.87) empirical ethics analysis

RESULTS: INTRA-NORMATIVITIES IN OLD AGE CARE WORK

The findings show how the socio-material context, and the use of different technologies shape the care practices and care practitioners' striving for the good care. We begin by describing each old age care context, and then continue with the results of the care practitioners' interview analysis.

Homecare as a Care Context

In recent years in Finland, social policy has aimed to reduce the proportion of institutionalized care and increase the proportion of homecare of older people. The staffing of homecare has not been sufficient, and the working conditions of homecare workers have deteriorated, as the number of homecare clients and the complexity of their health problems have increased (Kröger et al. 2018). Homecare services in Finland are a combination of home help services and home nursing, but in last years they have become more medical, and care focused (Ruotsalainen, Jantunen, & Sinervo, 2020.).

In municipal homecare, the practical nurse usually makes 8–12 client visits during the work shift, whereas during the evening shift and the weekends they may make up to 15 client visits. For the practical nurse, work at the clients' homes currently makes up 60% of their working hours, and their rest of the time is spent in transit between clients' homes and working in the office. Nurses usually make 2-4 client visits during the work shift, and the rest of the time they work in the office. The greatest problem in organizing work from the client's perspective is that care practitioners (nurses and practical nurses) constantly change, possibly resulting in up to 200 different care practitioners for a client over two years.

Finnish wellbeing and aging policy has primarily prioritized older individuals' autonomy and self-care, leading to rapid adoption of home-based welfare technologies (Kröger, 2019). Over the past decade homecare work has become increasingly technologized as, for example, various data systems and communication applications have been implemented in homecare

workers' daily routines. Simultaneously, older peoples' homes have turned into technological environments, meaning that the care workers also must take care of the functionality of the clients' technologies and guide their clients in their use. One of the main technologies affecting the daily organization of homecare work is an enterprise resource-planning (ERP) application on the homecare practitioners' mobile phones. This system is for supervisors to allocate homecare visits among the team, and then monitor them in real time. It functions in parallel with the patient record system and service planning system.

Intra-Normativities Triggered by Mobile Record-Keeping in Homecare

Homecare practitioners use their mobile phones at least two ways during the work shifts. The ERP application provides them with a scheduling and organizing tool as the system shows the client visits, their estimated lengths and the task lists. The homecare practitioner also uses the mobile phone to document the tasks and the health state of the client during the visit to the patient record system. The ERP shapes the work of the care practitioner and care as something which should be done within a time-limit, which creates sometimes difficulties in keeping up the planned schedule. *Being present with the client and facing them calmly regardless of the care practitioner' emotion that they are in a hurry, appears to be an intra-normativity* deriving from this situation. Rushing and time limits are pushed away from the care practitioner's mind, as one described:

> *When you're given a certain amount of time to be in their home, it's a rush somehow, like that, but as long as you don't show it to the client and you're calm, even though you know you're in a terrible hurry to do something, but still you are here and do everything calmly right to the end and, well...//...How can I explain? Just do things calmly. Even though I know I have to run afterwards, I don't think about it, I'm with the client for the moment, or I give them time and even sit and talk, not about work-related things. Then I give them the time if they want to talk or want someone to be present. It's important that someone is present and talks. So, I still take the time, even though I know I could just do my work and leave, but I still take the time to... It's just that, again, I'm not really... I don't look like I have to go somewhere else. (I44)*

However, care practitioners may experience portraying that they are not in a hurry as ethically strenuous (see Nikunlaakso et al., 2019). As was expressed in the excerpt: "Even though I'll have to run afterwards, I don't think about it, I'm with the client in that moment". They have to combine two contradicting demands of care work – being efficient and following the scheduled rhythm of visits and concentrating on each clients' needs and circumstances.

Other types of intra-normativities derive from the duty to document client data during the home visit. *An intra-normativity, which was common to the majority of the care practitioners was that they avoid looking at their mobile phones during their visits, in order to focus on interaction with the client.* "If I look at my phone all the time, the client may feel insecure" (I8), as one interviewee put it. As an earlier analysis (Koskela et al., 2023) on mobile documenting practice showed, care practitioners tend to develop several strategies to hide mobile record-keeping from the client, such as documenting without client noticing, using paper and pen instead of the mobile phone, or moving the documenting task outside the client

visit. This kind of avoidance of using mobile phone in the front of the client makes the care practitioners to orient themselves by reading in advance on their mobile phones who they are going to visit and what needs to be done. As an interviewee described:

> *But if, like, all this medicine stuff, even in [the name of the patient record system] was okay, yeah, you wouldn't be fidgeting and twiddling with your phone so much. That's why I've got into the stupid habit of reading the care plan before I start, because it's really embarrassing for me to go to a client's house and have my hand on my phone like this. Then I already know what I'm going to do and I can look the person in the eye and talk to them at the same time. (I49)*

As described in the excerpt, all kinds of changes in the ICT system, for example, having to find medication in the patient record system on their mobile phone during the visit was perceived as embarrassing because it would disturb the face-to-face contact. Therefore, fidgeting with the mobile phone was preferred to take place outside the client visit as much as possible.

Another kind of intra-normativity can be identified from the cases when the care practitioner multitasks with mobile documenting and a caring task. In these cases, the mobile documenting was explained to take place simultaneously with a caring action, as an interviewee described: “I put on the soundtrack of some popular music, rub the client from their shoulder while writing with one hand to the mobile phone.” (I45) *We can name this kind of intra-normativity as redeeming the use of technology with good deeds.*

In case the mobile documenting requires taking place right after for example medicine intake of the client, the care practitioner may justify it by apologizing from the client for being forced to focus on mobile documenting for a while, as an interviewee put it:

> *And then all those medicine administration records, they are so accurate, when you have to read every medicine there, really read there, so I am not really able to talk the same way as before. I might sometimes notice that I've been quiet for a long time, and then I just say to the client that I'm sorry that I have to write here, that's why I'm quiet. (I47)*

Although the care practitioners did not report any complaints from the clients for pausing the interaction, they tend to ask a permission for mobile record-keeping from the clients, as an interviewee explained: “I always say that, now I am documenting. They usually reply: Indeed, do so in peace.” (I47) Although the clients, who have been a long time as clients in homecare, are used to mobile documenting, *permission-asking or apologizing for using the technology by the care practitioner appears to be a typical intra-normativity*.

To summarize, these four kinds of intra-normativities of pretending not to be in a hurry, avoiding the technology use in front of the client, asking permission or apologizing it, or even redeeming the use of the technology by good deeds, reflect the value of prioritizing the human encounter and interaction, and not focusing to technology use when the client is present. However, the interviews of the care practitioners who made physical homecare visits revealed how planned schedules, embedded in ERP, and the mobile record-keeping obligation during the visits distracts the care practitioner’s attention from forming empathic relationships with the clients. This may cause ethical strain and a conflict between being

empathic (with time to listen to each client) and being a good worker (taking care of all the clients of the day on time, and mobile document their state during the visits).

Remote Homecare as a Care Context

Remote homecare in Finland refers to a service in which the care practitioner and the older client are in contact with each other via voice and the screen of a tablet computer (STM, 2020). In both our homecare sites, the municipality was about to increase the use of remote homecare (aiming to replace 20% of homecare visits by video visits). According to the supervisors, short home visits are replaced by video visits when clients can care for themselves and can be guided. A video visit is for making sure that the client takes their medicine, eats their meals, and does their exercises, or for when a client needs to chat for a while. The care practitioners reported that this strengthens the digital agency of the client, although the contact requires minimal technical effort by the client. The motives for remote homecare also derive from making care easier and more cost-efficient by centralizing remote homecare service: "Travel costs are saved, and a small number of care workers are able to provide care very efficiently to a bigger number of clients", as one supervisor described.

In the municipality in which we interviewed care practitioners from the remote homecare unit, typically, one or two care workers contacted 40 clients during the morning shift, and two care practitioners contacted 50 clients during the evening shift. In both our homecare research sites, the supervisors described the video visits as very positive, intensive work for the care practitioners, and as a channel for social contacts between elderly people, despite this being via a screen. The role of the care practitioners in maintaining the clients' technological tools seemed much smaller than in physical homecare work. It focused on reporting disturbances in the video technology to technical support.

Intra-Normativities in Remote Homecare with Video Visits

In remote homecare, the socio-material environment of the care practitioners is a landscape office, and they connect with clients via a screen, one call after another. Facial expressions stand out as a way of expressing emotions to the client, as physical touching is not possible. During the COVID-19 restrictions, the faces of the homecare practitioners who did physical visits were covered by masks, and thus the benefit of video visits was not having to wear masks. The care practitioner's smile was more easily seen by the clients and created a positive start to conversations, as an interviewee described:

> *I've noticed that, whether it's empathy or whatever, but I smile a lot. Sometimes I find myself smiling so much that when the call ends, my face is stiffened. Maybe a little too much sometimes. I've noticed that it's something that makes clients feel positive right away. (I4)*

Smiling through the screen can be seen as an intra-normativity that is enhanced particularly in remote homecare, because neither of the care practitioners making physical home visits mentioned the significance of smiling. Another difference in remote homecare compared to physical homecare is to be able to focus on interaction with the client during the video visit because care practitioners are not so busy helping or serving the client. The care

practitioners could not multitask during a video visit, which was experienced as making the interaction more focused and initiated a new kind of guidance talk, as one interviewee described:

> *After all, the encounter with the client is different in that you're present all the time, in a way, you're not able to do anything else at the same time, like I'm making coffee or porridge or something and sometimes I shout to the client to do this and that. That [in video visit] you're always face-to-face with the client and in a way you give all your time to them. And then of course the fact that the client has to do the things themselves, from a rehabilitative point of view. You can't help in any way, no matter how much you'd like to heat up the food for them, so it's a little easier and it doesn't take you so long. You just have to try to guide and help. (I12)*

This kind of encouragement of the client's autonomy can be named as an intra-normativity confined by the fact that the care practitioner cannot do physical caring acts in remote contact for the client. Learning and listening to what is going on in the clients' life is prioritized during a call, although the purpose of the call was defined as checking that medication was taken in time, as one care practitioner described:

> *The fact that our work is about listening to the client, even if the purpose of the call is to confirm they take their medication or that they take the medication during the call, you can't immediately, as soon as the call starts, you can't say A [name of the care practitioner] here: Just take your medication. No. You have to read the client. First, you ask, 'how are you' and then slide into the call, if the client doesn't immediately like to take their medication, sneak in the question about the medication: That is, you can't command the client to do things, otherwise they'll press the end call button. You have to be able to read the client by their gestures and speech. (I5)*

This excerpt reflects *an intra-normativity in remote care, not to be too straightforward or controlling in the client interaction*. Direct questions about medication would be experienced as rude, so the care practitioner listens to what is going on in the client's life instead and then sneaks in the question, if the care practitioners could not see via the screen the medicine intake taking place. This kind of indirectness in interaction displays respect toward the client.

Many interviewees described how reading the client via the screen is important, in order to observe whether they are lonely, sad or happy and to get to know them better in each call. The care practitioners seemed to prioritize creating empathic relations with their clients, while also maintaining their surveillance task. To nourish lively conversations with the clients, the care practitioners collected interesting topics to talk about with their clients into a notebook to share with colleagues. This kind of activity turns the attention from symptoms or pain onto the social life and life history of the client, thus strengthening the client's personhood and connectedness, as the person-centered old age care philosophies also suggest (Fazio et al., 2018). In this sense *encountering the client as a person in their life continuum, not only as a patient, can be identified as an intra-normativity* enhanced by the video visits as well.

To sum up, meeting via screens restricts remote homecare and clearly shifts the focus from simultaneous actions and talking to reading facial expressions and discussion. The care practitioner cannot gently touch or help the client physically, which is a restriction from the perspective of good care. Indirectness in determining whether the medical need has been fulfilled turns the care practitioners' attention to the clients' life in general, thus showing respect to the client. Four kinds of intra-normativities were identified triggered by the use of video visits: smiling, encouragement of the client's autonomy, not acting directly in a controlling manner, and focusing into client's life instead of symptoms in the discussion. All these formed the goodness of the remote homecare. The values brought into being through these intra-normativities refer to respecting client's autonomy and seeing the client as an agent in their own life context, which is enhanced by the fact that the care practitioner replaces their caring acts, and bodily movements by talking with the client and their interests.

Intensive Service Housing as a Care Context

In Finland, 24-hour service housing provides personalized care based on individual needs, regardless of the time. This encompasses functional capacity, meals, cleaning, and activities to promote participation and social interaction (Social Welfare Act, 2014). In ISH, care practitioners work around the clock, usually divided into morning, evening and night shifts. The facilities are often divided into group homes of 10–20 residents who need various kinds of help in moving, eating and in their existential vulnerabilities due to physical or mental impairments (Hämäläinen, 2022).

Technology use in these settings varies. In one site, technology was employed to foster social connections for older individuals, enabling video conferencing and tablet usage to engage with loved ones. This reflects a cultural shift in old age care, from passive nursing home residents to active participants integrated into society (Theurer et al. 2015). Social media has been embraced as it enhances the visibility and public perceptions of care of older adults. Sharing daily activities on social media has become part of care practitioners' roles but is still rare in general in old age care. Thus, intra-normativities, which derive from social media use and represent a new emerging work role of the care practitioners, are worth exploring.

Intra-Normativities Emerging with the Use of Social Media in ISH

Care practitioners in ISH spend their work shift moving between the private rooms of the residents and common spaces of the nursing home. Touching, hugging and verbalizing care tasks were described as forms of creating an empathic relationship with clients. A warm relationship between the care practitioner and the client may form without words, through eye contact and a gentle touch and voice. The care practitioners claimed that eye contact was an important way to communicate when they had to use facemasks during the COVID-19 pandemic. They used a significant amount of time helping the residents get up and get dressed, and taking them to eat, but there was also time for doing nice things together such as baking, singing, chair exercising, or going outdoors.

In terms of how social media use shapes care and relationships with clients, it seems that as a work task it activated care practitioners to think and even arrange more events and shared activities with the residents, as described in the following:

> *Well, probably in the way that you perhaps think more about, or come up with all kinds of events, nice things, in which the residents can easily participate and then it's nice to post Twitter photos. So, all the time you and your colleagues think what could be next, nice to do together. And the residents like it, you can really see that there's a smile on their faces. (I23)*

Social media use strengthened experiencing care as social activity, and in the interviews the care practitioners described how they posted photos on the organization's social media channels from the events, which they thought were somehow visually funny or beautiful. *This reflects an intra-normativity that social activities and their esthetics are an important part of care*. The care practitioners felt that social media use was seen as something fresh and increased their feeling of being up to date in their work. On the other hand, the purpose of using the social media was reported to show the world that old age care work could be as interesting as any other work, as expressed in the following excerpts:

> *I try to take social media into my work to show what my work is. So that it shows to the world that it isn't always washing asses, giving medicine, or moving the client from here to there. It can be normal activities, like in everyone's life. They are still people, although they are old people, they have a lot to live for. (I22)*

> *I am the one who chooses, what I think is worth immortalizing; this is the one photo I want to share with the world. (I22)*

This kind of intra-normativity is connected to a new kind of motivation to change the bad reputation of old age care by making the everyday care work transparent for their closest and the entire society, and something which the employees can be proud of. However, the care practitioners were aware that from the client's perspective the social media use does not make a difference to the elder client or improve care, as an excerpt explains:

> *For example if you think from the residents perspective, for them they are really old people and they don't really get any benefit, so either you put it on social media or don't, what activities are going on and that's the everyday thing that we're supposed to do for residents, they're getting no benefit, I think, social media is playing no role, but for organization, for advertisement purpose and for making nurses or the employers more active, it does. // personally I find it fun, especially when I have spare time so OK, let's put it that everybody knows that we are doing this, so yeah I think it depends from what side you are. (I26)*

To sum up, in ISH social media provides the care practitioner an opportunity to show loved ones and the audience the positive spirit of care of older people. Planning nice events for social media has even catalyzed activities that promote a good life (see also Levonius & Sivunen, In Press). Two kinds of intra-normativities were identified connected to social media use in care work: motivation to show social events with the clients increased seeing old age care more as a social and esthetic activity. Furthermore, postings of social media were seen as making an impact to society in seeing care of older adults in a more positive and

attractive light. From the ethical perspective, all the older people may not understand how they are an object of gaze or marketing material for the organization when their photo is posted in social media. However, this seems justified by the intention of the care practitioners to create a better reputation for care work in this era of dwindling resources for old age care and the shortage of employees. The values brough into being through these intra-normativities enhanced by the social media express that social activities are a valuable part of ISH, and old age care should be seen as a pride.

DISCUSSION

Our analysis contributes to the scarce number of qualitative studies studying use of technologies from the ethical point of view, as observed also by Hämäläinen (2020). It focused on how different technologies shape various intra-normativities in everyday old age care what is considered good care. We examined how care practitioners conceptualized their circumstances and practices for creating empathic relationships and caring about their clients in three different socio-material contexts. Although our aim was not to compare different old age care services as such, bringing them into a coherent, parallel, and contextualized analysis, help to better understand how the different technologies change the relationship between the care professional and the client, and what kinds of practical and ethical values are embedded in technology use situations.

The care practitioners in **homecare** expressed that time-bound visits and mobile documenting during home visits were the most disturbing obligations, and that they possibly challenged the sensitive encounters with clients and caused ethical strain. The intra-normativities derived from mobile technology use during client visits indicated that care practitioners tended to hide both their mobile documenting task and that fact that they were in a hurry, in order to not jeopardize the flow of interaction with the client. The practices of combining mobile documenting with good care during short home visits were various (Koskela et al., 2023), but all of them reflected that interaction with the client was valued more than the use of technology. It seemed that the care practitioner tried to keep the home visit as focused to the clients' needs as possible, as if the technological task did not bother at all, or if it did, it was a matter which should be apologized or compensated. Compared to research findings of Bergshöld (2018) and Tufte (2013) about use of similar technologies, the values of the care practitioners behind the intra-normativities in our study seem to be more human-centered, not seeing the technology turning care work as mechanical and efficient performance. On the other hand, our study is in line with the previous studies' (Bergshöld, 2018; Tufte, 2013; Hämäläinen & Hirvonen, 2020) finding that care practitioners do not only adapt to the mobile documenting, but they also create their own practices to tame it to better suit care work. Furthermore, our findings indicate that such care ethicists' virtues as attentiveness, responsiveness, and respect (Noddings, 2013), in the client encounter are still enacted although the care practitioners use mobile technology during their home care visits.

Although the entire setting of **telecare** can be seen in ethical sense problematic, as surveillance invading privacy of the clients (Mort et al., 2013), the care practitioners aim to enact good care via video appointments, shaping their own intra-normativities how to create goodness in them. In remote homecare the opportunity for good care is confined by

encountering the client via screen. Therefore, the care practitioners expressed empathy through facial expressions, such as smiling, eye contact, and words. The perceptions of the care practitioners indicated that contrary to general concern, the shift from physical homecare visits to video-mediated remote homecare does not necessarily imply a shift from human-centered care to distant and emotionally cold care. Remote homecare seemed to intensify the client–care practitioner interaction, as the technology mediation enabled the care practitioners to concentrate better on the clients' issues and lives. Whereas during homecare visits focusing on activities for a good life was rare, in remote homecare the carers and clients could at least talk about them extensively. Intra-normativities embedded in video-mediated interaction included an indirect way of approaching clients' symptoms or illness or asking about the medicine intake. The screen made it possible for the care practitioner to see if the medicine was taken during the video visit, although the conversation was flowing around other things. Previous research on telecare showed how the clients as users modify telecare for their own purposes or reject the use if it does not fit their expectations (Mort et al., 2013). Our analysis unfolded how care practitioners in remote homecare may act in empathic way and consider clients not just patients but human beings who need to be socially connected.

In **ISH**, the use of social media as part of care work displayed empathic relationships and social events in residential care under the lens of the public eye. The care practitioners even made an extra effort to arrange events for the older people, to be able to post these on social media. Social media triggered an intra-normativity of seeing old age care more as a social and esthetic activity. However, according to research on residential care, more social events do not necessarily make residents' life more meaningful if they lack opportunities for their own contribution or reciprocity (Theurer et al., 2015). If the criterion for arranging social events derives from esthetics and entertainment, triggered by the social media demand, the purpose of making the event meaningful from the client point of view may be lost. In addition, from the ethical point of view, older people may not understand social media enough and it can be difficult for them to refuse being the object of the public gaze (Levonius & Sivunen, 2024). The reconciliation of ethical principles in social media and care has not been extensively studied (Lemon & Boman, 2022), and this kind of setup is rare in any case. Therefore, more research on how the use of social media shapes care workers' practices is needed. On the other hand, social media as part of care practitioner's work provides an almost a revolutionary opportunity for presenting care work in a more positive light for the citizens as a source of wellbeing, not only as a cost for the society.

As our analysis indicated different technologies create different intra-normativities to old age care and change the understanding of what is considered good care. Although care practitioners struggle to keep the quality of old age care not to be disturbed by mobile documenting in homecare, focused conversationally on client's social connectedness and good life in remote homecare and take the opportunity to improve the image of old age care with the social media, the practice of caring may benefit from reminding of care ethicists' values of good care. Intra-normativities should be seen as relational (Pols, 2015), creating different kinds of goodness depending on from whose point of view they are looked from: client's, practitioner's or the old age care service system's. An example of a contradictory and problematic intra-normativity is the use of social media with older people to gain better image for the old age care. Presenting good care is not the same as good care.

CONCLUSION

We found and made visible how the use of mobile documenting, remote homecare via video visits and social media use in residential care shape how old age care is enacted and what is considered good care in care practitioners' daily work. The technologies in care work functioned as a channel for communication between professionals, between professionals and clients and between care community and wider public. Although we focused into one technology in each old age care context for the sake of clarity, the future of technologization of care may include the use of several technologies in every care practitioner's work. However, different intra-normativities shaped by the technologies bring different values into being. In condensed form they can be named: 1) prioritizing the human encounter and interaction over mobile record-keeping in homecare visits, 2) considering the client as an autonomous agent in their own life context, not only as a patient in remote homecare conversations, and 3) arranging social activities in old age care as a showcase, which improves the public image of old age care via social media.

One limitation of the analysis is that it was based on interviews of care practitioners and not on observations of work, or the clients' perspective. Observations of the interactions between care practitioners and clients were analysed from the perspective of good care and empathy in our previous article, showing how these intra-normativities may function in everyday care work (Saari, Koskela & Känsälä 2024). The interviews provided a point of departure for the ethnographic part of the study. Interviewees tend to mostly explain the way in which they would ideally like to act, although hindrances and excuses when the empathic relationship became obsolete in the situations were also discussed.

IMPLICATIONS FOR THE POLICY AND PRACTICE

As a whole, the care practitioners' perspectives and their intra-normativities indicate that they are able to use technologies for striving to attain good care practices, although the implementation of technologies in the political sphere has been justified with the values of cost-efficiency and coping alone of the older people rather than provision of better care (Kröger, 2019). To guarantee good old age care during the era of digitalization, the care practitioners should have enough time for creating their own digital agency and ethical understanding of the different welfare technologies. Organizing care work to support autonomous, flexible ways to act in such a way that care practitioners may find their way to use technology for responding to the clients' needs and provide good care, should be a priority as it benefits the well-being of both clients and care practitioners. Continuous reflection of care practices within work communities, and at the societal level are needed, when new technologies are implemented in old age care. The findings of research approach of empirical ethics may provide a possible point of departure for these ethical discussions and evaluations.

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All correspondence should be addressed to
Eveliina Saari
Chief scientist, Finnish Institute of Occupational Health,

P.O.Box 40, FI-00032 TYÖTERVEYSLAITOS, Helsinki, Finland
eveliina.saari@ttl.fi

Vilja Levonius
Researcher, Finnish Institute of Occupational Health
P.O.Box 40, FI-00032 TYÖTERVEYSLAITOS, Helsinki, Finland
vilja.levonius@ttl.fi

Inka Koskela, Researcher
Finnish Institute of Occupational Health
P.O.Box 40, FI-00032 TYÖTERVEYSLAITOS, Helsinki, Finland
inka.koskela@ttl.fi

Tiina Koivisto,
Senior Specialist, Finnish Institute of Occupational Health,
P.O.Box 40, FI-00032 TYÖTERVEYSLAITOS, Helsinki, Finland
tiina.koivisto@ttl.fi

Marja Känsälä
Specialized Researcher, Finnish Institute of Occupational Health,
P.O.Box 40, FI-00032 TYÖTERVEYSLAITOS, Helsinki, Finland
marja.kansala@ttl.fi

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