

---

The Role of Telecare in Older People's Daily Lives: experiences, practices and attitudes

Working Papers from the AKTIVE project 2011-2014

---

AKTIVE Working Paper 3

Telecare and older people's  
social relations

Emma-Reetta Koivunen

CIRCLE (Centre for International Research on Care, Labour and Equalities)  
University of Leeds

---

Advancing Knowledge of Telecare for Independence and Vitality in later life

Published by CIRCLE, University of Leeds, April 2014

©University of Leeds, University of Oxford and the author

ISBN 978-0-9928741-2-4

Online version: <http://www.aktive.org.uk/>

Also available from: CIRCLE

Centre for International Research on Care, Labour and Equalities  
University of Leeds, Leeds, LS2 9JT, UK

Tel: (+44) 113 343 4872

Web: <http://www.sociology.leeds.ac.uk/circle>

Email: [CIRCLEadmin@leeds.ac.uk](mailto:CIRCLEadmin@leeds.ac.uk)

## Acknowledgements

### *Research, analysis and development of the working paper*

Data discussed in this paper were collected and analysed by the researchers responsible for the AKTIVE fieldwork: Kate Hamblin and Emanuela Bianchera (University of Oxford) and Emma-Reetta Koivunen and Gary Fry (University of Leeds). With Sue Yeandle (who directed the AKTIVE project and edited the AKTIVE working papers), these colleagues also advised on the content and development of this paper. The author gratefully acknowledges their contributions.

### *Research participants*

The research team is extremely grateful for the contribution made to the study by the older people who took part, sometimes in difficult circumstances, who allowed us into their homes, gave generous and thoughtful interviews, permitted us to observe their living situation and assisted us by completing diaries, taking photographs and in other ways helping us gain a full picture of their everyday lives. We also wish to thank their family members, home care workers and others involved in their care who agreed to be interviewed or observed or who completed questionnaires. These contributions were vital to the study, which would not otherwise have been possible. To protect the confidentiality and privacy of those who took part, all names, and some identifiable details, have been changed.

### *Funding of the AKTIVE project*

The main funding for AKTIVE was provided by the Technology Strategy Board (TSB), which developed the scheme through which the project was funded in collaboration with the Economic and Social Research Council (ESRC) and the National Institute for Health Research (NIHR). AKTIVE industrial partners Tunstall Healthcare (UK) Ltd and Inventya Ltd also contributed resources to the project. AKTIVE was originally funded under the name '*The Potential of Assisted Living Technologies for Older People at Home: creating a knowledge base for businesses developing technology for dementia and falls*', contract reference number 400215 / 2592-25185.

## 1 Introduction

This paper focuses on the social relationships in the everyday lives of participants in the AKTIVE study and considers how telecare fits into these. The paper examines types of relationships and how these change, with a focus on being cared for and on the loneliness which many participants experienced. After discussing these aspects, the paper explores how telecare fitted into these relationships, assesses the extent to which social relations support or hinder telecare use, and discusses research participants' experiences of this. The paper addresses three of the AKTIVE project's research questions, adding to knowledge of: the characteristics of older people who use telecare and the contexts in which they do so; how telecare is used and affects those involved; and barriers to the adoption of telecare<sup>1</sup>.

The paper complements others in the AKTIVE Working Paper series which explore related topics: the 'caring networks' which offer some older people support (Yeandle, 2014b, Paper 2); the bodily frailty which many older people confront (Fry, 2014, Paper 4); and issues of identity, stigma and choice (Hamblin, 2014, Paper 5). Here the focus is on social relationships and interactions, on difficulties such as loneliness, and on what support telecare offers frail older people in managing these.

Definitions of telecare usually highlight the way different types of equipment support older people to remain independent and safe at home (Yeandle, 2014a, Paper 1; Roulstone et al., 2013). Telecare also works as a system connecting people: the older person, the response centre and those attending the scene (wardens, friends or family members, emergency services staff). It operates as a means of communication connecting these people, producing outcomes for multiple social actors in the situation: social and health care professionals, users of services, their families and / or carers; and social care commissioners (TSA, 2013).

In examining older people's social relationships and how telecare fits into and affects these, the paper builds on sociological research on the use of technology, much of which has focused on information and communication technologies (ICTs) (Buse & Koivunen, 2013). Theories of the 'domestication of technology' (Haddon, 2006) add another perspective and explore how technology becomes embedded into the routines of everyday life (Silverstone et al., 1992). This process is shaped by social relationships at every stage, including the introduction of technology, support for its use and how the technology is perceived (Hynes & Rommes, 2006). Pols and Willems (2011) argue that technologies have 'expected' uses. They liken these to a 'script', but comment that these 'scripts', prepared by designers of the equipment and system (Gill & Grint, 1995), may not fit easily into care practices (Latour, 1992, cited Pols & Willems, 2011). Further, as the concept of 'interpretative flexibility' highlights, different social groups can create their own uses for technology, which may differ from intended uses (Wacjman, 2000; Reed, 2009).

Some research on older people's social relations and ICTs, such as the Internet (Russell et al., 2008), has examined the role of these technologies in combating loneliness and sustaining social relations (Ring et al., 2013; Jones & Rowbottom, 2010). Other technologies have also been found to 'mediate' social contact for some older people. Thus in England, where 51% of people over 75 live alone, 5 million describe the

---

<sup>1</sup> The research questions and methodology for the AKTIVE project are available in Yeandle et al. (2014).

television as their main form of company (NHS, 2013). Some studies highlight negative findings, claiming technology may be replacing care provided by a person (EFORTT, 2011).

Owing much to Townsend's influential study (1963), academic research has long focused on older people's social relations. In the study reported here, frail older people described their social relations with family members, neighbours and friends (some of whom had now also become their nominated 'telecare responders') as well as people employed to assist them, including home care workers, other health and social care professionals and staff connected to the telecare system (assessors, installers, and staff in the telecare monitoring centres and emergency services). Some also spoke at length about people important to them earlier in life, such as former colleagues and neighbours and people close to them who had died.

Demographic changes, including the ageing of the population and an associated increase in demand for care, combined with families living at greater distances from each other and women's increased employment rates, affect older people's social relations, as older people become relatively more numerous and younger generations less so, and as services to meet their needs are rationed, redesigned, outsourced or privatised (Hamblin et al., 2013; Yeandle et al., 2012). Others note that older adults *'often rely on members of their social network for emotional and instrumental (i.e. practical or financial) support, yet they may expect and desire different types of support based on the nature of a particular relationship'* (Carr and Moorman, 2011: 146), and report differences in relationships based on their 'voluntariness' (choice in entering the relationship), 'permanence' (ability to terminate the relationship) and 'duration' (how long the relationship has existed) (p145).

Much of the literature on older people's social relations focuses on loneliness and social isolation. Wenger et al. (1996) differentiates 'social isolation', having limited social contact, and 'loneliness', negative feelings about perceived isolation, noting that changes that can lead to isolation for older people include bereavement, particularly being widowed, outliving contemporaries (Hadley and Webb, 1974, cited Wenger et al., 1996), moving, and retirement (Hovaguimian, 1988, cited Wenger et al., 1996).

Another strand has highlighted relationships with close family members, including 'daughters who care' (Lewis and Meredith, 1988; Qureshi and Walker, 1988), patterns of familial reciprocity and obligation (Finch, 1989; Finch and Mason, 1992) and relations with neighbours (Bulmer, 1986; Willmott, 1986).

This paper explores new data collected through Everyday Life Analysis (ELA), a methodology using ethnographic observations and interviews with older people over a period of six to nine months. Research participants were supported to create maps of their social relations to help identify the people who supported them, who were also interviewed or observed wherever possible (Yeandle et al., 2014). The methodology used produced a holistic understanding of how the older people studied used telecare, conceptualising it as a process which cannot be separated from the wider context of their everyday lives and social networks, and which fitted into, and sometimes changed, these.

## 2 The social relations of the AKTIVE research participants

To set the scene for exploring how telecare affected and fitted into the research participants' social relations, this section introduces them and their social relationships. Of the 60 older people who completed the longitudinal study, 41 lived alone and 19 with someone else (most with their spouse, but some with an adult child or grandchild) (Yeandle, 2014a, Paper 1, Table 1.1; and Appendix to the AKTIVE Working Paper Series). Their ability (or otherwise) to leave their homes alone or unaided was an important factor in their social relations. In all, 37 research participants said they were still able to go out alone; many of them valued their regular participation in events or social situations outside the home, which included visiting pubs, participating in interest groups or activities designed for older people, and socialising with family and friends. A few in this category had rich and supportive networks (Yeandle, 2014b, Paper 2). Those with limited ability to go out, particularly as a consequence of mobility difficulties, reported that almost all their social interactions now took place within their home (supplemented, for some, by contacts with significant people in their lives by phone, online or by letter). Among these, many experienced social isolation or loneliness, some suffering considerably from one or both of these (see also Hamblin, 2014, Paper 5).

Table 3.1

Research participants by living circumstances and telecare in place at recruitment

	Living alone	Living with someone else	Total
AKTIVE ELA participants:	41	19	60
<i>With home care workers</i>	15	9	24
<i>With (family / friend) carers</i>	40	16	56
<i>Able to go out alone</i>	26	11	37
ELA participants' telecare:			
<i>Pendant alarm only</i>	23	9	32
<i>Telecare package</i>	16	8	24
<i>GPS tracking device</i>	2	2	4
<i>Other (single item)</i>	1	1	2

Source: AKTIVE ELA Database, CIRCLE, University of Leeds.

Social relationships were a particular focus of discussion in one of the six scheduled ELA research visits. During these visits the researcher helped the research participant to 'map', and talk about, all the people in their life. In these sessions, research participants often spoke about death and loss and mentioned friends and family members who had died, or who were no longer able to visit because of poor health or disability. At the start of the study eight research participants were divorced and 33 were widowed; two more lost their spouse during research contact.

Mrs Allen's health, particularly her sight, had deteriorated since her husband died, affecting her mobility and ability to socialise. Several family members visited her, but they did so less often than she liked.<sup>2</sup> She commented:

*I get very, very lonely and nobody can understand loneliness unless they've been there themselves... You see, my kids say to me, 'You want to get out more, mother. You want to go and visit people and do this and do that'... I'm thinking, for \*\*\*\*\* sake, I can't even see to \*\*\*\*\* well get out. They make me swear, and say naughty things that I wouldn't think of, but it's true; I can't do what I can't do. They said, 'You can't always have people come to see you', and I'm thinking, 'Well, come and fetch me then', you see? Kids, they've got a life of their own now, I suppose; they've got enough to do.*

Mrs Allen, 84, falls, living alone, Oxfordshire

In this case, her expectations of the quality and quantity of social interaction with her family were not met. Similar experience was mentioned by others in the research sample, sometimes explained, or nuanced, by comments about, and recognition of, other pressures in family members' lives.

### **Box 3.1 Mrs Richards: telecare and loneliness**

Mrs Richards was a widow aged 93 who had arthritis and impaired hearing. She had a pendant alarm and key safe because of mobility problems and her fear of falls. She lived alone in Oxfordshire in the house where she had lived for over fifty years. When discussing her life, Mrs Richards spoke about the deaths of her daughter (as a baby) and husband (six years before) and of losing friends. She described vividly her life with her husband: *'It was lovely. I've been ever so happy really, until [my husband] went'.*

Now unable to leave her house, her social interaction had become limited to visitors coming to her home. Most evenings she cooked a meal for herself and her daughter, who visited each day after work, and felt this kept her mother active and encouraged her to eat well. When her daughter went on holiday, she arranged for her partner's parents to visit Mrs Richards to ensure she had fresh milk and supplies. When Mrs Richards was interviewed shortly after this, however, she said she had had no visitors. For her, the visits arranged by her daughter were practical, rather than social, visits and did not count as, nor meet her need for, social interaction.

Mrs Richards' telecare was installed after her husband died. Her recollection of it was not very clear, *'I can't remember now exactly who decided that I should have it. I think it must have been a social worker'.* She was happy to have it as *'it makes me feel safe when I'm here alone'.* She wore her pendant all the time when she in the house, apart from when washing. Mrs Richards had had several false alarms. During the first, her daughter *'panicked'* and rushed to her, but since then she had learned to call Mrs Richards first to check on her. Because of hearing and mobility problems Mrs Richards found it hard to cancel false alarms. Telecare supported Mrs Richards to remain in her own home. However, her main problem was loneliness and social isolation, and for her, the telecare she had in place did not make a difference to this.

<sup>2</sup> All research participants' names have been changed. Further details of individual research participants are given in an appendix to the AKTIVE Working Paper Series.

For some of the 24 research participants who had home care in place, their most regular social contact now was seeing their care worker(s). Mr Crosby (79, Leeds) cared for his 75-year old wife, whose frailties included both susceptibility to falls and dementia, and who was attended several times a day by home care workers who provided all her physical and personal care. Mr Crosby was capable of going out alone, but caring for his wife severely limited his ability to do so. His opportunities to socialise with others were restricted (although he still regularly attended Leeds United football matches) and he only left the house when Mrs Crosby had a care worker present as a companion.

While the telecare this couple had in place (including a 'carer alert' device linked to a sensor on Mrs Crosby's chair) was not used to increase Mr Crosby's activities outside the home, within and around it the telecare gave him much valued freedoms, including enabling him to continue leisure activities in the house and garden. During the study the way the couple used the telecare changed, and some equipment (a bed sensor and fall detector), no longer used, was set aside as Mrs Crosby's mobility became more constrained and her health deteriorated.<sup>3</sup>

Other changes in later life, such as moves to live with family or into residential care, also had implications for social interaction, and for some in the study, created new (or strengthened existing) social contacts. Mr and Mrs Woodhouse, a frail couple aged 87 and 88, lived in Leeds. Her mobility was severely constrained and he also had mobility problems, although he was able to go out alone using walking sticks. The couple's telecare support comprised a smoke alarm linked to a monitoring centre, and pendant alarms, which both wore. Mrs Woodhouse's pendant was fitted with an 'easy press' adapter to help her use it when needed. When Mr Woodhouse went into the garden (where he had experienced several falls), she found it reassuring to have this means of communication should he be outside when she needed help.

Later, when Mrs Woodhouse was hospitalised for an extended period, Mr Woodhouse attended a local lunch club, but as he explained: *'When she came out, I didn't go, because I didn't want to go and leave her here, and me going out.'* Mrs Woodhouse died during the study, and in an interview a few months after her death, Mr Woodhouse was obviously sad. This change in his life nevertheless had a positive impact on his social interaction, highlighting the complex and shifting nature of older people's social relations, which go beyond the 'voluntariness', 'permanence' and 'duration' identified by Carr and Moorman (2011), and form the context for understanding their experiences of isolation or loneliness. Mr Woodhouse now felt able to attend the lunch club regularly; he enjoyed going out and meeting new people and joked about being among 'old' people, as most people at the lunch club were in their nineties: *'Nearly everybody on the table is virtually ninety or more. So I'm a boy, really (laughs).'*<sup>4</sup>

Social relations, loneliness and changes (often involuntary) in relationships create complexity in older people's everyday lives, and, with changes in health, are part of the context and circumstances in which telecare is used and responded to, and which may lead to changes in their use of and need for telecare.

---

<sup>3</sup> Before the study, when Mrs Crosby still had some limited mobility, she used a fall detector and bed sensor to ensure her husband would be alerted if she fell. However, before joining the study her mobility declined significantly and these were no longer needed. While Mr Crosby felt competent with the equipment, he was unsure who to contact about their changed situation, so the equipment was stored in their house rather than sent back to the telecare provider.

<sup>4</sup> Hamblin, 2014, Paper 5, examines how making comparisons to others who are or who behave as 'older' can help some research participants to adjust to new identities.



### 3 Telecare and social networks

The local contexts for the assessment, allocation and installation of telecare equipment in research participants' homes, outlined elsewhere (Yeandle, 2014a: Paper 1), meant there were some differences in the telecare arrangements they experienced. Some (particularly those in Leeds) had 'packages' of telecare (usually comprising some '2<sup>nd</sup> generation' equipment), while most others (including many in Oxfordshire) had only a '1<sup>st</sup> generation' pendant alarm; a few had another single item of equipment or a more modern '3<sup>rd</sup> generation' device, such as a GPS tracking system.<sup>5</sup>

This section examines the processes involved as telecare entered the everyday lives of the research participants and considers how different members of their social networks responded to it. Many other people in their lives, including family members and neighbours, were involved in or affected by the telecare arrangements, through a set of processes which included acquiring the equipment, installing it in their home, establishing emergency response arrangements and responding to alarms and alerts.

#### Acquiring telecare

Research participants acquired telecare for three main reasons: a change in their living situation, such as becoming widowed and starting to live alone; changes in their health (often involving hospitalisation, a fall, or progress in their dementia) in response to which health or social care staff suggested telecare; and 'inheriting' telecare, either from a previous occupant of their home (often someone they had cared for previously, such as a spouse or disabled child) or having telecare 'as standard' on moving to supported housing. Social relationships were central to the decision to use telecare, particularly in the first two of these, with family members, or others involved in their care, responding to these changes by organising or encouraging the acquisition of telecare, usually with the aim of managing perceived risks associated with ill-health and living alone in later life.

Participants' experiences of telecare installation varied. Some found it straightforward. When interviewed, Mrs Barnard, aged 90 and with dementia, who lived with her daughter in Leeds (who was present during the interview), spoke positively about the installation technician, '*we had an awful nice wee man, didn't we?*', and explained that he had quickly shown them how it worked. This experience, seen among other participants too, supported telecare use. For others, complexities in the installation situation limited the older person's or their carers' understanding of the system. Quite often telecare had been installed while the research participant was in hospital; and in some cases family members were not present during the installation, which could create problems affecting subsequent use of the equipment (Box 3.2 and Box 3.3).

Some older people experienced the telecare installation as a stressful social situation. Mr Whittaker (77, falls, living alone, Leeds) had an equipment upgrade which the researcher was able to observe. When he joined the study he had stated that he disliked meeting new people, and during the technician's installation visit he became anxious and was clearly relieved when the technician left. In a social situation that was stressful for

<sup>5</sup> 1<sup>st</sup> generation telecare refers to pendant alarms, 2<sup>nd</sup> generation telecare includes sensors which monitor risks in the home or actions, and 3<sup>rd</sup> generation equipment in the study included GPS tracking devices (Yeandle 2014a).



him, it was evident that understanding details of telecare equipment and the system was difficult. Although he was used to his pendant alarm and smoke detector, first as a carer for his wife and later for himself, the new features of his upgraded equipment, which were explained during the installation, caused him concerns later on.

**Box 3.2 Mr Carlson: family networks and ‘domestication’ of telecare**

Mr Carlson was an 80 year old widower with Alzheimer’s Disease. He lived alone in the Leeds conurbation and had a telecare package which supported him to live independently. This included a GPS tracking device, memory minder, several sensors (for heat extremes, smoke and gas leaks), a pendant alarm and a medication dispenser.

Mr Carlson’s son-in-law was present when the telecare was first installed, after which the family felt they knew how the technology worked. However, the first GPS tracker Mr Carlson had was too complicated for him to use, and the family asked if there was another type available which he could have. When this was installed, no family members were present. Mr Carlson’s son-in-law commented:

*The [telecare technician] came when we weren’t there. So they didn’t give us any instructions on how to use it or anything, and we still don’t know. It’s silly, because when we came round he’d got no idea what it was or anything. So we’ve just sort of gone blindly with it, haven’t we?*

Carer (son-in-law), supporting Mr Carlson

Nonetheless, Mr Carlson used the GPS tracker on his daily walks. His daughter explained that he had used it in an emergency (although, because of his memory problems, when this was discussed in an interview, Mr Carlson said he had never used it). He also took it with him when he went by train to the city centre once a week to meet an ex-colleague in their regular pub.

Mr Carlson’s family were actively looking for solutions to support him and used various methods to support his independence. These included low-tech approaches, such as reminder signs around the house, and high-tech approaches, such as telephone screening. They also modified these approaches when needed. For example, he had problems using his medication dispenser and called his family about this repeatedly. His daughter, son-in-law and two adult grandsons, who lived nearby, arranged for a family member to visit him daily, to ensure he took his medication and help him with domestic tasks.

Mr Carlson was using the equipment successfully and it had become part of his daily routines. Uncertainty about how the technology worked, combined with his memory problems, still caused concern to his family, however.

Telecare systems rely, at least to some extent, on users' local social contacts, who become their nominated responders and key holders and are contacted if an alert is triggered. Leeds' and Oxfordshire's telecare services both also offered the option, for those without such personal contacts, of using their service's own mobile responders (in Oxfordshire at additional cost for those paying charges for telecare).<sup>6</sup> Different values impacted on the decision of who should be a responder.

Mr Swallow (74, prone to falls and with memory problems) and Mrs Swallow (67, also susceptible to falls) had pendants and a key safe installed in their Oxfordshire home. They decided to use the mobile responder service. Mrs Swallow explained that her son would attend if they had problems, but lived in a nearby town and travelled by motorbike. For his safety, they did not want him to drive over feeling anxious:

*I spoke to [my son] ... because [he] is the first one I'll call whenever anything happens, obviously, and he said that he would be the responder, but if they could have an outside person, you know, he would come immediately he was called, but he wouldn't be on his motorbike thinking, "Oh my God, I've got to get there, I've got to get there." It would give him that little bit of leeway of just organising his end, so he can get to us.*

Mrs Swallow, 67, falls, living with husband, Oxfordshire

Several other people in the study also expressed concerns, saying they felt unsure how the system worked, or who would attend them in an emergency. In most cases this did not stop them from using telecare, but better knowledge of how their equipment worked in practice would have improved confidence both among the older people themselves and their family members.<sup>7</sup>

### Relationships, support and barriers to use of telecare

Social relationships can support telecare use both before the equipment is installed, and once it is in place. Some research participants knew about telecare in advance, as older friends or relatives had used telecare. This encouraged them to feel the technology would be useful, and gave a social context for seeing it as normal. Some older people in the study had previously used telecare as a carer, often caring for their spouse, and in a few cases for a disabled son or daughter, although this did not necessarily lead to early acceptance of it. Mr Harper, who had experienced telecare when caring for his late wife, commented:

*I never thought of getting one for myself until the hospital advised it [a pendant alarm]. And the hospital advised it because they thought that, yeah, if I collapsed [once], you know, I could collapse again. I haven't done since two, three, years now, but their occupational health department decided I would be better with one.*

Mr Harper, 73, falls, living alone, Leeds

<sup>6</sup> Telecare provision in the two local authorities is explained in Yeandle (2014a, Paper 1) and there is further discussion of social contacts as 'caring networks' in Yeandle (2014b, Paper 2).

<sup>7</sup> See the Appendix to the AKTIVE Working Paper Series for a summary of positive and negative responses to specific items of telecare equipment.

Many research participants valued their independence and being able to cope on their own (as discussed in Hamblin, 2014, Paper 5). Remaining 'independent' could also have a more negative side, however, as some older people, particularly those living alone, worried about 'being a burden' to family and friends, or 'bothering' them. These views could affect their use of telecare; some spoke about not wanting to activate the telecare or to 'bother anyone', by which they could mean their nominated responder, staff at the monitoring centre, or medical or emergency services staff who might attend them.

Mrs Woolley lived alone in Leeds and, aged 83, was prone to falls. She and her daughter (in a separate interview) both described the importance they attached to maintaining her independence following her husband's death. Acquiring telecare was part of this approach, and Mrs Woolley had a pendant alarm and a bed sensor installed. Mrs Woolley's aim of remaining independent and 'not being a bother' had affected her attitude and thinking about telecare. She had never used the equipment in an emergency, and said she would be hesitant to do so. Her next door neighbour had agreed to be a responder but Mrs Woolley did not feel comfortable about her neighbour being contacted by the monitoring centre, especially at night, as she had a young family. She also felt her neighbour had some reservations about the responder role:

*No, I don't think she wants the responsibility, I get that feeling. That she will help out, but she doesn't want the responsibility, she doesn't want to feel that she is my sole, you know, because [my daughter] doesn't live immediately here. So I don't push that one, no, no.*

Mrs Woolley, 83, falls, living alone, Leeds

As discussed in this section, social relationships played a key part in acquiring telecare and initial perceptions of it. These could either support research participants to view the equipment in a positive light, or alternatively make them feel uncertain about using it. The following discussion examines the continuing importance of older people's social relationships, both in living with telecare and in using it, either in emergencies or in dealing with false alarms.

## 4 Changing relationships, changing telecare use

Getting used to the equipment, experiences of using it in an emergency and dealing with alarms and alerts (false or otherwise) were part of the lived experience of telecare. Through these, the technology could become 'domesticated' into daily practices and accepted. Alternatively, negative experiences could deter or limit use of the equipment, leading to its lack of use or rejection.

Several research participants reported positive interactions with the telecare response centre. Mrs Cooper (68, Leeds) had a pendant alarm for falls, but when she lived independently had been hesitant about using her equipment in an emergency. She explained: *'I'm used to it now. You know, you just get used to it.'* This change was linked to her move to sheltered accommodation, where the telecare system linked her to wardens on the site, rather than to family members or paramedics. This arrangement had made her feel more comfortable about using the equipment when she needed help: *'Here, I don't feel as though I'm bothering anybody. It's their job.'*

Stressful experiences when telecare had been activated could hinder future use, however, and negatively affect views of the equipment. This sometimes happened because experience did not match expectations. After a fall, Mrs Black used her pendant alarm to get help, but had to wait on the floor for some time. Although she needed help to get up, she did not want to go to hospital as she felt she had not injured herself. She was upset by the response she received:

*I think they may have been paramedics, but I'm not sure, but they were very nasty to me... because I would not go to hospital [laughs]. So, that was that.*

Mrs Black, 80, falls and memory problems, living alone, Oxfordshire

Misleading or confusing information and experiences could also lead to problems in 'domesticating' the telecare equipment. Mrs Cash had been on the phone when an alarm had gone off. She explained that a voice (from the monitoring centre) had suddenly 'come through her phone':

*Suddenly this voice knew my name and everything, and [Mrs Cash] you've got a fire, you've got something on fire.' It kept on. I thought it was somebody messing about.*

Mrs Cash, 76, falls, living alone, Oxfordshire

This experience left her feeling uncomfortable with the telecare equipment. She felt uncertain about the system 'taking over' her telephone, and worried that the fire brigade might arrive unnecessarily, when she was certain she did not have a fire.

### Box 3.3 Mrs Clayton: telecare and behavioural effects

Mrs Clayton was 77 years old and (at the start of the study) lived with her husband. She had suffered a stroke which left her partly paralysed. She had been home from hospital for a few weeks when she joined the study. Mr Clayton had problems with his heart and with mobility, and died during the study. Mr and Mrs Clayton were a close couple who had married in their 50s. Each had children from previous marriages. They had lived in their house for over 20 years and had friends in the area, and daily visitors. Mrs Clayton also had care workers four times a day.

Telecare was suggested by an occupational therapist while Mrs Clayton was in hospital. Mr Clayton was at home when the fall detector and smoke alarm were installed:

*[It was] very straightforward. I didn't say a word to the young guy, he just got on with it. And I didn't even know they'd put that smoke alarm ... and then [he] put the [fall] detector there. And then there's the speaker, you know, respond with the girls in the office ... he just got on with the work, and he was very quick.*

While the installation was straightforward, Mr Clayton said during the first research visit that he wasn't quite sure how the equipment worked. During research visits, Mrs Clayton's fall detector was always on the adjustable table next to her. She did not wear it, as one of her arms was paralysed and she was only able to use one arm. The couple did not feel this was a problem, as the table was always next to her and she was hardly ever alone.

They had a false alarm when Mr Clayton was cooking. The smoke alarm went off and the monitoring centre contacted them. He explained to them what had happened and the centre ended the call. *'And then the thing went off again, and the next thing I know, there's the fire brigade outside.'* Mrs Clayton described hearing her husband say: *"Oh, bloody hell."* I was saying, *"What's the matter?"* He said, *"The fire brigade is here."* Later, after Mr Clayton's death, Mrs Clayton recited the story again. She said the firemen had been very nice, adding that after that Mr Clayton *'never did toast again'*. Although the interaction with the fire service personnel was polite, the experience left him adjusting his behaviour to avoid a similar occurrence in the future. Despite these problems, when Mrs Clayton was moving to live closer to her son after her husband's death, she and her family felt it important for her to have telecare in her new home too.

Others described gaining confidence, and feeling comfortable with the technology. Miss Chester was an 89 year old single woman. She lived alone and was supported by her extended family. She had experienced falls in the past and family members had spoken to her about getting a pendant alarm. She explained that while she was willing to consider this, she did not *'like the look of them'*. Her great-niece described Miss Chester's reaction, *'She said, "I like wearing my pearls. I don't want a pendant."* When she was hospitalised after a fall, however, the physiotherapist suggested Miss Chester could use a wrist-worn fall detector instead. Since using this equipment, she had experienced several false alarms, one of which alerted her nephew and called him to the house, and one which led to the fire brigade attending. The reactions of the monitoring centre, her nephew, the firemen and her friend (who was present on the second occasion) all supported her to view these events as 'test runs', rather than as embarrassing incidents (in contrast to the experience described in Box 3.3). Miss Chester

later described telling her friends about the advantages of her pendant alarm and her 'intercom', as she called the system. Through these experiences of use, and the supportive feedback she received from her social contacts, her views had changed from hesitation, to seeing telecare as something that enhanced her life, and through these experiences she had become a keen advocate for telecare.

### How telecare affects relationships

In several cases telecare had helped to improve relationships, especially for people with dementia and their carers. Mrs Peters was 67 and had dementia. She lived in Leeds where her husband cared for her at home. Her Alzheimer's disease had progressed rapidly, necessitating major adjustments for the couple. Mr Peters found the medication dispenser useful, as it was equipment Mrs Peters could easily relate to:

*And I'm able to say to her now, whereas she was taking three of one pill, two of another, none of another (...) I've set them out in the pill popper, I can say to her, 'Take your pills', and she will go to that and tip it upside down and take it, won't you? And I usually stock it on the day when she's at the day centre, so she's not interfering [laughs] with it, so from [her] point of view, it's a never ending supply.*

Carer (husband), supporting Mrs Peters

The equipment supported him to care for her and reduced some tensions in their daily interactions.<sup>8</sup>

While telecare can improve relationships by linking the older person to a source of support, it may also play a part in, or be a source of, tension in relationships. Some research participants and their carers had differing views about when telecare equipment, such as a pendant, should be worn, or in which situations they should use it to call for help. Mr Lindsay (66, Leeds) had early onset dementia and lived with his wife. Their case is of particular interest as their experiences with telecare initially increased, but later significantly reduced, tensions in their relationship.

Part of their support arrangements was a GPS tracker for Mr Lindsay to take with him when he went for a walk with their dog. The couple had differing views about how Mr Lindsay managed when he was out alone. Mrs Lindsay worried about him, but Mr Lindsay said he did not really need the device: '*When I got it, I didn't want to know, to be quite honest ... I'd leave it on the mantelpiece*'. His wife persisted in advocating use of the device and reminded him about this repeatedly, and he started keeping the GPS tracker with him more regularly, still viewing it as something for his wife, rather than something he needed himself. '*It would help with peace of mind of [my wife], just to be quite honest really*'. Later he was out walking, had a fall and became confused. '*I turned round quickly and, you know, for that (snaps fingers), that little second, I didn't know where I was*'. After that experience he said he would not go for a walk without his GPS tracker. For this couple, the telecare device initially caused friction, Mr Lindsay initially changing his behaviour only for his wife's 'peace

<sup>8</sup> By contrast, several research participants with dementia who lived alone had problems using the medication dispenser, which has two relevant features: an alarm to alert the user to take their tablets and a sensor which recognises when the tablets have been dispensed and turns off the alarm. The sensitivity of the tilt mechanism on which the sensor relies meant some users experienced continuing alarms, even after their medication was dispensed. Others were taking their tablets out of the dispenser but then forgetting to take them. In these cases, the use of the dispenser was abandoned and replaced by administration of the medication by care workers or family members, who also provided the older person with other support or reassurance.

of mind', but eventually his experience of feeling confused when out alone made him see the GPS tracker as an important part of his daily routines.<sup>9</sup>

### Telecare, loneliness and connectedness

Several older people in the study said having telecare in place meant they did not feel so alone, and for them it helped combat some feelings of isolation and loneliness. Mrs Tyne commented: *'If anything happens, you're not on your own, you can just press the button and somebody will come'* (94, falls, living alone, Oxfordshire); similarly Mrs Cash explained: *'I always feel as if somebody's there if I really need them. As you know, it connects to that, and somebody will come, well, within reason'* (76, falls, living alone, Oxfordshire).

Many carers also commented on this. Mrs Murray's daughter was the main carer for her mother aged 86. Mrs Murray lived alone in Leeds, was prone to falls and had a pendant alarm and a smoke detector. Her daughter described the benefit of telecare as knowing that her mother was not fully alone if *'something happened'*. While telecare did not provide significant social interaction for the research participants, many of them and their family members felt the connection it created was important. The (mainly unrealised) potential for aspects of telecare systems to help older people combat loneliness and isolation is discussed in Yeandle, 2014b: Paper 2.

---

<sup>9</sup> These issues are also discussed by Fry (2014, Paper 4) and Hamblin (2014, Paper 5).



## 5 Discussion: telecare in the everyday lives of older people

This paper has examined the processes AKTIVE research participants had experienced in making telecare part of their everyday lives, with a particular focus on the role of social relationships in these developments. The use of telecare does not happen in isolation from other aspects of older people's everyday lives, and their abilities, interests and social networks all affect how they use and view the technology. Findings reported in this paper suggest older people's social relationships could play a more prominent role in supporting their use of telecare at every stage, from when information about telecare is initially received, through early views about it, acquiring and installing the equipment, and helping the older person to view positively their experiences of using it (whether for emergencies or in cases of false alarms). By engaging the support of everyone involved with the older person, their different social contacts could help them through the process of 'domesticating' telecare into their routines of everyday life.

At present, the telecare installation process does not systematically include an older person's socially significant contacts, even though another person (family, friend or others) is often, but not always, present in installation situations. Many older people have support networks whose members could help them incorporate telecare into their everyday lives and routines, and most encountered in the AKTIVE study seemed willing to do so. As shown in Box 3.2, Mr Carlson's family helped him use and understand his telecare equipment. However the information they received was limited and as a result they did not feel fully competent themselves in using it. Installation situations and first impressions of the equipment are particularly significant moments, which shape understandings and perceptions of telecare and can support or hinder its use in the future.

Experiences of using the telecare equipment, and the responses of monitoring centre staff, nominated responders and emergency or medical staff also affect how older people view the telecare equipment and how they are likely to respond to it in the future. Positive experiences help ensure telecare becomes a part of routines. However, one negative experience can discourage use of the equipment or affect other aspects of behaviour, as shown by Mrs Clayton's husband (Box 3.2). Where family members or other social contacts feel they understand how the telecare system works and its purpose, they can support the older person to see false alarms as 'test runs' which help build confidence in the system, rather than as embarrassing incidents to be avoided.

People in the older person's social network also need enough information and support to feel empowered to support their use of telecare. Their openness to telecare as part of the support system surrounding the frail older person (e.g. by being key holders) can support or hinder its use. Telecare is installed to support safety and independent living, which were important concerns for many research participants. However while the telecare equipment allocated often met this need, limited social interaction and loneliness were even more pressing concerns in the everyday lives of many. To them, telecare seemed separate from these and had no impact on these problems, as discussed in Box 3.1.

Research participants' needs, social situations and abilities varied and were changing, even during the study period. For many, their social networks were crucial for the successful incorporation of telecare into their everyday routines, yet for others such relationships were less significant, or had limited impact on their use of telecare, and assessors need awareness of this variability in older people's circumstances. Changes in older people's social relationships, living circumstances and abilities mean their use of telecare is a dynamic process, and arrangements to support it need to be flexible, kept under regular review, and to engage and support significant others in their lives.

## References

- Bulmer, M. (1986) *Neighbours: the work of Philip Abrams*, Cambridge: Cambridge University Press.
- Buse, C. and Koivunen, E.-R. (2013) 'Understanding telecare: insights from the sociology of technology and ageing', pp. 24-32 in AKTIVE Consortium, *The Role of Telecare in Meeting the Care Needs of Older People: themes, debates and perspectives in the literature on ageing and technology*, AKTIVE Research Report Vol.1, online publication: [www.aktive.org.uk/publications.html](http://www.aktive.org.uk/publications.html).
- Carr, D. and Moorman, S. M. (2011) 'Social relations and ageing', in R.A. Settersten and J. L. Angel (eds) *Handbook of Sociology and Social Research*, 145-160, New York: Springer.
- EFORTT (2011) *Ethical Frameworks for Telecare Technologies for Older People at Home*, Final research report, University of Lancaster.
- Finch, J. (1989) *Family Obligations and Social Change*, Cambridge: Polity Press.
- Finch, J. and Mason, J. (1992) *Negotiating Family Responsibilities*, London: Routledge.
- Fry, G. (2014) *Coping with Change: frail bodies and daily activities in later life*, AKTIVE Research Report Vol. 2, Working Paper 4, Leeds: CIRCLE, University of Leeds, <http://circle.leeds.ac.uk/>.
- Gill, R. and Grint, K. (1995) 'The gender-technology relation: contemporary theory and research', pp. 1-28 in R. Gill and K. Grint (eds) *The gender-technology relation: contemporary theory and research*, London: Taylor and Francis.
- Haddon, L. (2006) 'The contribution of domestication research to in-home computing and media consumption', *The Information Society*, 22 (4) 195-203.
- Hadley, R., Webb, A. and Farrell, C. (1975) *Across the Generations*, London: George Allen & Unwin.
- Hamblin, K. (2014) *Risk, Freedom and Control in Older People's Lives: the relevance of telecare*, AKTIVE Research Report Vol. 2, Working Paper 6, Leeds: CIRCLE, University of Leeds, <http://circle.leeds.ac.uk/>.
- Hamblin, K., Darowski, A. and McShane, R. (2013) 'Demographic ageing, falls and dementia', pp. 3-23 in AKTIVE Consortium, *The Role of Telecare in Meeting the Care Needs of Older People: themes, debates and perspectives in the literature on ageing and technology*, AKTIVE Research Report Vol.1, online publication: [www.aktive.org.uk/publications.html](http://www.aktive.org.uk/publications.html).
- Hovaguimian, T., Grab, B. and Stuckelberger, A. (1988) 'Psychosocial problems and the health of the elderly with special reference to social isolation', *Danish Medical Bulletin: Journal of the Health Sciences Gerontology: special supplement series*, 6, 2-7.
- Hynes, D. and Rommes, E. (2006) 'Fitting the internet into our lives: IT courses for disadvantaged users', in T. Berker, M. Hartmann, Y. Punie and K. Ward (eds) *Domestication of media and technology*, Maidenhead: Open University Press.
- Jones, M. and Rowbottom, C. (2010) 'The role of telecare in overcoming social exclusion in older people', *Journal of Assistive Technologies*, 4 (3) 54-59.
- Latour, B. (1992) 'Where are the missing masses? The sociology of a few mundane artefacts', pp. 225-259 in W.E. Bijker and J. Law (eds) *Shaping technology / building society. Studies in socio-technical change*, Cambridge: MIT Press.
- Lewis, J. and Meredith, B. (1988) *Daughters Who Care: daughters caring for their mothers at home*, London: Routledge.
- NHS (2013): 'Loneliness in older people', NHS Choices. <http://www.nhs.uk/Livewell/women60-plus/Pages/Loneliness-in-older-people.aspx>.
- Pol, J. and Willems, D. (2011) 'Innovation and evaluation: taming and unleashing telecare technology' *Sociology of Health & Illness*, 33 (3) 484-498.
- Qureshi, H. and Walker, A. (1988) *The Caring Relationship*, London: Routledge and Kegan Paul.

- Reed, D. (2009) 'The performativity of a volunteer-based telecare service', 112-131 in Loader, B. D., Harder, M. and Keeble, L. (eds) *Digital welfare for the Third Age*, London: Routledge.
- Ring, L., Barry, B., Totzke, K. and Bickmore, T. (2013) 'Addressing loneliness and isolation in older adults', *Affective Computing and Intelligent Interaction (ACII)*, Humaine Association Conference, 2-3 September 2013, Geneva.
- Roulstone, A., Harrington, B., Fry, G. and Buse, C. (2013) 'Assisted living technology and telecare: the policy and practice context', in AKTIVE Consortium *The Role of Telecare in Meeting the Care Needs of Older People: themes, debates and perspectives in the literature on ageing and technology*, AKTIVE Research Report Vol.1, online publication: [www.aktive.org.uk/publications.html](http://www.aktive.org.uk/publications.html).
- Russell, C., Campbell, A. and Hughes, I. (2008): Ageing, social capital and the Internet: Findings from an exploratory study of Australian 'silver surfers', *Australasian Journal on Ageing*, 27 (2) 78–82.
- Silverstone, R., Hirsch, E. and Morley, D. (1992) 'Information and communication technologies and the moral economy of the household', 15-31 in R. Silverstone and E. Hirsch (eds.) *Consuming Technologies*, London: Routledge.
- Townsend, P. (1963 [1957]) *The Family Life of Old People: an inquiry in East London*, Middlesex: Penguin Books.
- TSA (2013) *Telecare service providers in Scotland and the Scottish Ambulance Service – working together to improve service delivery* TSA good practice guide, Scottish Centre for Telehealth and Telecare, Joint Improvement Team and Telecare Services Association.
- Wajcman, J. (2000) 'Reflections on gender and technology studies: in what state is the art?', *Social Studies of Science*, 30(3): 447-64.
- Wenger, G. C., Davies, R., Shahtahmasebi, S. and Scott, A. (1996) 'Social isolation and loneliness in old age: review and model refinement', *Ageing and Society*, 16, 333-358.
- Willmott, P. (1986) *Social Networks, Informal Care and Public Policy*, Research Report 655, London: Policy Studies Institute.
- Yeandle, S. (2014a) *The AKTIVE Study and Working Paper Series* AKTIVE Research Report Vol. 2, Working Paper 1, Leeds: CIRCLE, University of Leeds, <http://circle.leeds.ac.uk/>.
- Yeandle, S. (2014b) *Frail older people and their networks of support: how does telecare fit in?* AKTIVE Research Report Vol. 2, Working Paper 2, Leeds: CIRCLE, University of Leeds, <http://circle.leeds.ac.uk/>.
- Yeandle, S., Buckle, P., Fry, G., Hamblin, K., Koivunen, E.-R. and McGinley, C. (2014) *The AKTIVE project's social, design and prospective hazard research: research methods*, AKTIVE Research Report Vol.3, online publication: [www.aktive.org.uk/publications.html](http://www.aktive.org.uk/publications.html).
- Yeandle, S., Kröger, T. and Cass, B. (2012) 'Voice and Choice for Users and Carers? developments in patterns of care for older people in Australia, England and Finland', *Journal of European Social Policy*, Vol. 22, No. 4, 432-445.

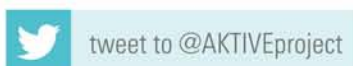


phone: +44 (0) 113 343 5003

email: [contact@aktive.org.uk](mailto:contact@aktive.org.uk)

web: [www.aktive.org.uk](http://www.aktive.org.uk)

CIRCLE, School of Sociology and Social Policy, University of Leeds, LS2 9JT, UK



AKTIVE partners:

