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From back-to-face to face-to-face?: Video visits slowing down the pace in homecare

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Abstract: There is a belief that the pace of society is accelerating due to digital technologies, but there is also concern that these technologies will replace care staff and negatively impact the quality of care for older people. In 2023, a Swedish municipality began offering video visits to homecare users, yet little is known about the implications of this digital technology on the perception of time. This article explores the temporal effects of video visits in homecare, based on a qualitative study of 33 interviews with a digital homecare team and care users. The findings show that although video visits were generally shorter than home visits, both the digital homecare team and care users felt that video visits slowed down the pace of conversations, as the digital homecare team could focus entirely on the care users. During home visits, care staff had to perform practical tasks while conversing, leading to 'back-to-face' communication.

Keywords: Homecare; video visits; Sweden; time; technology

1 Introduction

Digital technologies are increasingly used in social work (Goldkind et al., 2023), not least in relationships with clients and care users (see Nordesjö et al., 2022; Henze-Pedersen & Kirkegaard, 2025 for overviews). In research, concerns have been raised about the challenges when 'social work comes to the small screen' (Pollack, 2008: 841). However, especially since the Covid-19 pandemic, it has become more common for social workers across contexts to engage in screen-mediated communication and meet clients via video (Goldkind et al., 2023). As digital technologies continue to develop and be used in new settings and for new social services, it is important to gain greater knowledge of this ongoing development in social work and how digital technologies influence social work practice.

This article focuses on a specific context within social work, *homecare*, which, in many countries, including Sweden, faces challenges due to increased life expectancy and care needs. At the same time, there is a shortage of care staff. Digital technologies have been proposed as solutions to this challenge, as they are expected to increase efficiency in terms of both time and cost within homecare (cf. Milligan et al., 2011; Swedish Government & Swedish Association of Local Authorities and Regions, 2021). However, there are concerns that implementing new digital technologies will replace care staff and negatively impact the quality of care for older people. For instance, Aanesen et al. (2011:161) argue that "there is general resistance to substituting 'warm' hands with 'cold' technology" (see also Milligan et al., 2011; Pols, 2012). In both healthcare and social work, relationship-building with care users and meeting them in person is highly valued and at the core of professional identity (cf. Nordesjö et al., 2022). In these debates, increased time efficiency and meeting care users in person are often described as opposing and incompatible logics and practices (see Scaramuzzino, 2019, for social workers). The discussions are based on core values and ideals of care work, such as providing warmth,

continuity, and stability (Hale et al., 2010), which can be easily lost in municipalities' efforts to digitalise welfare services (cf. also Frennert, 2019).

In times of austerity and constant welfare cutbacks (Cummins, 2018), care work is often constrained by time, making it challenging to provide care in accordance with these ideals (Andersson & Sjölund, 2022; see also Balkin et al., 2023, for nursing homes). In homecare, busy schedules and time pressure mean that care staff have little time to talk to care users (cf. Ernsth Bravell et al., 2021; Jönson et al., 2024). Previous research highlights that care staff sometimes must even cut home visits short (Bergschöld, 2018) or do not have the time to show up at all (Jönson et al., 2024), as they must prioritise work tasks and allocate care to users based on who has the most urgent needs. However, as homecare becomes increasingly digitalised, it is crucial to empirically investigate the implications of digital technology on the perception of time.

This article aims to understand the temporal implications of video visits in homecare relations. While video visits have become a common digital health service (Milligan et al., 2011; Rosenlund et al., 2023), they are not yet widely used in Swedish homecare. In late spring 2023, a Swedish municipality began offering video visits to some care users as a complement to physical home visits to counter future staff shortages. The goal was to reach 200,000 video visits per year, which equals about 10% of the municipality's total home visits. The digital homecare team also wanted to increase care users' options and offer more flexibility. They also wanted to increase care users' feelings of safety and strengthen them so they could do more for themselves. Because offering video visits in homecare was new in Sweden, the digital homecare team had to test which homecare services could be delivered digitally and how, as well as whether digital homecare could offer new services via tablets. Video visits often lasted between a few minutes and 15 minutes. At the time of the study, the digital homecare team used tablets to remind care users to wake up, take their medicine, eat, and check in before and after activities such as showering or walking, as well as having social contact. However, as it turned out, regardless of the assistance the care users had been granted by social services, video visits often included casual conversations and small talk. This article is based on a qualitative interview study with a Swedish municipal digital homecare team and care users. Even though the article focuses on digital homecare in one Swedish municipality, the findings can be relevant to both other homecare organisations and other areas of social work, as screen-mediated communication becomes increasingly common. The concepts of *pace* and *presence* are used to capture how video visits were experienced and valued by both the digital homecare team and by care users.

2 Theoretical framework: pace and presence

Conceptualising time is not easy. The concept of time is multidimensional, used in many ways, and has different meanings. There is actual time, which is objective (e.g., 'clock time'), but time is also subjective because people experience it differently (perception of time). When there is a discrepancy between these two time measurements, it can lead to the feeling that time either flies by or slows down (Bagley et al., 2021). Time is also valued in different ways. This article focuses on how time is experienced and valued by the digital homecare team and by care users.

Rosas's (2013) theory of social acceleration will be used to understand how, and why, digital technologies tend to influence both actual and perceived time, and what happens when there is a discrepancy between them. As digital technologies can overcome spatiotemporal distances, there is often an assumption that they lead to *accelerated time* (Rosa, 2013). For example, within a single hour, care staff might be able to conduct four video visits instead of two home

visits, since no travel is required. However, depending on what type of digital technology we consider, what it is used for, and how it is used, digitalisation can also contribute to an actual or perceived slowdown of the pace of care. In this article, video visit technologies are seen as "objects of time" that shape temporality (Birth, 2012), and how temporality is shaped is an empirical question.

There is a connection between how time is perceived and social presence, and there is often an assumption that where the visit takes place matters for the possibilities to communicate and demonstrate presence, especially whether it occurs in a physical room or digitally. In this article, social presence theory will be used to analyse the experience of building relationships via video visit technology. The theory was introduced in 1976 and focused on telecommunications (Short et al., 1976). Since then, the theory has been developed and, for example, used to understand screen-mediated communication in social work (see e.g. Simpson, 2017). According to this theoretical perspective, people use both verbal (e.g., words) and nonverbal (e.g., tone of voice, facial expressions) cues while communicating. These cues include socio–emotional information which can make people feel both present and authentic in interaction (Short et al., 1976; Kreijns et al., 2022). However, it is not only whether the encounter takes place in a physical room or digitally that shapes possibilities to communicate and show presence.

Different mediums also affect interaction in various ways. For example, mediums that allow immediacy, face-to-face meetings, and eye contact make it easier to communicate warmth, closeness, intimacy, and availability (Kreijns et al., 2022). The contrast between 'cold' and 'warm' has often been used to describe the absence or the presence of social presence in meetings (Short et al., 1976). Instead of using the dichotomy between absence and presence, I will use two types of presence in caring relationships: 1) *being there for the care user*, and 2) *being with the care user*. Both types of presence are interpersonal and intersubjective. However, the first type of presence refers to attending to the care user's needs and is often related to actions or interventions. The other type of presence refers more to giving of oneself and being available and at the disposal of the care user. This is more about meeting and being present as whole persons, not only according to given roles, and being vulnerable in the encounter. It is about listening and wholeheartedly making room for the care user. These different types of presence usually yield distinct outcomes (Fredriksson, 1999: 1171). Social presence is connected to the experience of quality when being with the other person (Power et al., 2024), but digital technologies used in care work have seldom been associated with social presence (cf. Nordesjö et al., 2022; Milligan et al., 2011):

> Theorists of medicine as well as lay people often put healthcare technology, including telecare, in opposition to warm human care and contact. They assume that medical technology is cold, rational and functional, whereas human care is affective and comforting (Pols, 2012: 25).

Care work has been associated with warmth, face-to-face meetings, being in the same physical room (cf. Nordesjö et al., 2022; Milligan et al., 2011), and the ability to touch (Short et al., 1976). However, video visits, which are primarily based on immediacy, can also be considered face-to-face encounters, since care staff and care users can see each other on the screen. These visits can be described as *mediated encounters* (cf. LaMendola, 2010: 3–6) or technology-mediated communication (Oh et al., 2018: 1), as the interaction is mediated through the screen, affecting the ability to communicate verbal and non-verbal cues, build relationships, and convey presence. It is commonly assumed that digital technology acts as a filter and constraint between 'us' and the 'real' world (Pors, 2012). Social presence has been described as the

experience of "being there with a 'real' person" (Oh et al., 2018: 1; see also LaMendola, 2010), and this experience is particularly important and challenging to evoke when interacting and building relationships over screens.

3 Previous research

This article contributes to two strands of research: 1) studies on screen-mediated communication in social work, and 2) studies on how homecare is temporally organised and experienced.

Screen-mediated communication in social work has been called 'window work' (Grünenberg et al., 2022: 23). There are previous studies of screen-mediated communication in different settings, such as child welfare services (Andersen et al., 2018; Henze-Pedersen & Kirkegaard, 2025), labour and welfare administration (Løberg & Egeland, 2021), and eldercare (Grünenberg et al., 2022), but also, for example, during the COVID-19 pandemic (Cook & Zschomler, 2020; Mishna et al., 2021). Studies show that, on the one hand, screens both frame and delimit the encounter (Løberg & Egeland, 2021), tend to create distance in social worker-client relationships, and that establishing new relationships with clients via a screen was especially challenging (Cook & Zschomler, 2020). On the other hand, the physical distance can bring new forms of 'unexpected intimacy' (Andersen et al., 2018: 58). Using video allowed for more small talk and showing each other pets, hobbies (Andersen et al., 2018), and private homes (Mishna et al., 2021), which tended to strengthen the relationship. A challenge, however, was maintaining professional boundaries (Mishna et al., 2021; Henze-Pedersen & Kirkegaard, 2025).

This article also contributes knowledge to previous research on how homecare is temporally organised and experienced. Studies show that during the last few decades, there have been great organisational and temporal shifts in homecare work (Twigg, 2020; Strandell, 2022). However, in Sweden, there is variation in how homecare is temporally organised. Some municipalities have standardised the time allocated to services, with each home visit lasting the same amount of time, almost down to the minute, while others have allocated less specific time for each home visit (Strandell, 2022). Regardless, homecare has become strongly associated with clock time, time efficiency, time scarcity, time pressure, and busy schedules (cf. Tufte, 2013; Bergschöld, 2018; Strandell, 2022; Palmqvist, 2022). In fact, it has been described as a "battle on time" (Tufte, 2013: 97), but also as a battle over the values of care.

Research (Davies, 1994) indicates that homecare follows a process time logic, which is incompatible with a clock time logic. The process time logic is based on values such as respect, empathy, affection, and flexibility, acknowledging that unexpected events often occur in care situations, making it impossible to allocate exact times for each visit. Organising homecare based on clock time logic has been heavily criticised, yet according to research, digital technologies have facilitated such development. For instance, care staff use smartphone apps to track and save time (Bergschöld, 2018). These technologies are used to control and 'discipline' care staff, who often feel monitored and mistrusted by their employers (Strandell, 2022: 217). Many municipalities no longer offer grocery shopping and delivery services; instead, they assist care users with eGrocery shopping online, which is later delivered by the store (Frennert, 2019). Previous research shows that care users felt care staff had little time to talk (cf. Ernsth Bravell et al., 2021; see also Balkin et al., 2023 for nursing homes) and adjusted their routines to fit the busy schedules of homecare staff (Ernsth Bravell et al., 2021; Palmqvist, 2022; Voie et al., 2024; Jönson et al., 2024). Care users also compensated for the lack of services due to time

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scarcity by performing tasks themselves or refraining from making further demands on care staff (cf. Palmqvist, 2022; Jönson et al., 2024).

Previous research strongly emphasises screen use as a limiting factor in social work and care work and focuses on time efficiency. Studies on slowing down the pace are rare. One notable study on artists working in care homes for people with dementia explores care users' experiences of time and pace, and how art activities foster collaboration and slowness (Hatton, 2019). This indicates a potential empirical and theoretical 'bias' within these research fields. For example, much of the organisational and temporal shifts in homecare are interpreted through the lens of neoliberal governance, New Public Management reforms, austerity policies, welfare cutbacks, and streamlined time (cf. Tufte, 2013; Palmqvist, 2022). Digital technologies are often equated with these developments (cf. Strandell, 2022). This article contributes to previous research by broadening the perspective on time, pace, and presence and by focusing on the digital homecare team - care user relationship.

4 Method

The research application for this study has been written in collaboration with the municipality under study. The research idea to focus on the temporal implications of using video visits, the temporal organisation within the organisation, and the relationship between technology and time came from previous studies and from being the first municipality in Sweden to offer video visits to homecare users. The agreement was that the municipality should assist in providing access to different types of time data, recruiting interviewees, and collaborating on the dissemination of results. As a researcher, I had an independent role in interpreting and analysing the empirical material. When the data were analysed, a workshop was organised with managers and the digital homecare team to present the findings so that they could be used in their continued development of digital care. There were no conflicts of interest.

The collaboration also allowed me to follow the pilot project from the start. The digital homecare team recruited care users to their pilot project who they thought could use the tablet they provided, had care needs that could be handled via a tablet, and would benefit from video visits. Trying out or continuing to use video visits was optional. Some care users had only video visits, while most had both home and video visits. In general, the care users interviewed were positively inclined toward video visits, which may be partly due to their being optional.

The empirical material for this article was gathered through a qualitative interview study with the digital homecare team and the care users. A total of 33 interviews were conducted between June 2023 and May 2024 with 29 individuals (5 were follow-up interviews, as 1 interview was with 2 people at the same time). A total of 14 semi-structured interviews were conducted with the digital homecare team (first-line managers, coordinators, development manager, system technician, and care staff). First-line managers were initially interviewed together. Later, a follow-up interview was conducted with one of the first-line managers. Four of the staff who had been on the project from the start were also interviewed again after a year. In connection with these follow-up interviews, new personnel were interviewed, as the personnel increased during the course of the project. A total of 10 personnel from the digital homecare team were interviewed.

A total of 19 care users were recruited to participate in the study by the digital homecare team. The digital homecare team was instructed to inform care users who had used video visits for a few months about the study, let them know that their participation was voluntary, and allow them to choose where they wanted the interview to take place. A total of 13 interviews were

held via video calls, 3 via telephone, and 3 in care users' homes. The care users interviewed were of different ages (ranging from around 70 to 90+); 14 were women and 5 were men. The interviews lasted about between 8 minutes and 1 hour. The average duration of an interview was about 29 minutes.

The study has been approved by the Swedish Ethical Review Authority. The biggest ethical challenge has been anonymizing interviewees sufficiently so that their identities cannot be revealed, given that it was a small pilot project. To protect interviewees from being identified, pseudonyms have been used; their exact ages, times, and interview durations have been omitted.

All interviewees consented to their interview being recorded. Interviews were then transcribed, analysed, and thematised, and quotes were translated from Swedish to English. The theoretical distinction between actual, subjective, and valued time was present in data collection and analysis from the start, as was an understanding that this analysis focused on experienced and valued time. A thematic analysis method (cf. Nowell et al. 2017), with initial codes, was used to organise the empirical material into larger themes, which eventually resulted in two broad categories: 1) slowing down the pace in conversations, and 2) from back-to-face to face-to-face. During the coding of the empirical material, the focus was on temporal aspects in relation to the use of video visits. Each theme begins with an analysis of the digital homecare team's experiences with temporal aspects and video visits, followed by an analysis of care users' experiences. This means that the digital homecare team's and the care users' experiences have been analysed both separately and in relation to each other. The method helped identify key features in the empirical material and capture different perspectives (cf. Nowell et al. 2017). Previous research and the theoretical perspectives on *pace* and *presence* were used and developed after empirical material was sorted to deepen the analysis.

5 Slowing down the pace in conversations

In general, video visits were quite short, according to clock-based time. They often lasted between a few minutes and 15 minutes. Still, video visits were not experienced in this way. In this section, I will explore how time was perceived by the digital homecare team and by care users and why there was a discrepancy between clock time and how time was perceived.

5.1 Digital homecare team

In line with previous research (Tufte, 2013; Bergschöld, 2018), interviewees described how care staff in physical homecare sometimes had to speed up visits to maintain their busy schedules, especially due to various emergencies that could arise during shifts. However, pace and the passage of time during video visits were experienced differently. According to the digital homecare team, the lack of disruptions during video visits allowed them to focus entirely on the care user, providing full attention and a more relaxed interaction:

> Being able to talk to them (care users) a bit in peace and quiet as well. Because it can also be like this that if you have a long drive to see a care user and you know that you are stressed, then you will speed up that visit even more. But we can take it easy instead and maybe talk longer than we would normally have done. (Kim)

Instead of having to rush away to the next home visit, as has been described in previous research (Tufte 2013; Bergschöld, 2018), the digital homecare team could sit down and talk without time pressure. Another interviewee described the difference in pace between home visits and video visits as follows:

> For me, it is much calmer, and I hope I can communicate that (to the care users who have digital homecare) (…) I am the kind of person who, even when very stressed, tries not to show it. I always try to still 'see' the person I am with and put other things aside. But sometimes (in physical homecare), this can be very difficult due to high time pressure. My ambition is always "now I am here and focus[ing] on you who I am here to help". But if you have the emergency phone (in physical homecare), and it suddenly rings, it disrupts my focus. I must take the call and possibly arrange for a colleague to handle the alarm, which causes a lack of focus on the person I am with, creating stress for both of us. We avoid all such disturbances here (in digital homecare). (Filippa)

The digital homecare team found that video visits had fewer disruptions compared to home visits, such as emergency phone calls (cf. Bergschöld, 2018). This made it easier for them to truly "see" the person they were with. The digital homecare team could focus entirely on the conversation and the care user, which seemed to affect how time was experienced. They noticed a slowdown in the pace of conversations with care users.

5.2 Care users

At the beginning of the project, digital homecare did not have fixed allocated times for each video visit. Video visits were often shorter than home visits, but sometimes lasted longer. Tilde described how long her video visits usually lasted:

> I have not timed it, but 5 minutes max. They (care staff) ask how it is and sometimes they ask whether you have done anything special, and I have told them what I have done or…They ask if I have eaten or something. A little different, different times. I think, it is not a long conversation. It is not. (Tilde)

Some interviewees viewed video visits merely as reminders or check-ups. However, most perceived them as something more. One interviewee mentioned: "it lasts a few minutes so that we exchange a few words about what I have done during the day and so on. So, I really appreciate that" (Jane). Several care users noted that the duration of visits depended on their mood and whether they had something special to share: "yes, it usually does not last very long. For about 4–5 minutes at the most. If it has been longer, it has mostly been me who has kept them going if I have had something special to talk about, yes between 5 and 10 minutes" (Havanna). Another example was: "yeah, we talk a little bit about what I am going to have for dinner and stuff like that. What should we say, 3–4 minutes, maybe 5. It depends on what fun things we have to talk about" (Stella). The topic and personal chemistry between the care user and care staff also influenced the length of the visits: "I think I spoke for a quarter of an hour today, sometimes it can be much shorter. It depends on me too. It depends a little on who calls if I feel like talking" (Ottilia). Care users felt they could influence the length of conversations, extending them if desired, without experiencing strict time limits.

However, even though video visits were generally shorter in duration, care users overall experienced a slower pace in the conversations during these visits. This allowed for more relaxed and focused interactions, enhancing the quality of communication between care staff and care users.

> They simply have time. I asked them how much time they have, and they said it ranges from 5 to 15 minutes, usually taking 15 minutes. That is the big difference (between physical homecare and digital homecare). It is a slower pace. It is a slightly different pace for those poor people working with the other (home visits), you cannot escape that. But I do not have much to complain about them at all (physical homecare). In comparison, it is

> simple. The nice thing about video visits is that there is no rush, and you can talk in peace and quiet (Dennis).

Care users were careful not to compare physical homecare and digital homecare negatively. When they did, they added that they were satisfied with both and saw them as complementary. However, they noted that video visits were less rushed, allowing for calmer conversations. One rewarding aspect was that discussions were not limited to medical or health issues: "you have someone to talk to, and you do not exactly have to talk about illnesses, but about everything' (Lovisa). Care users felt they could talk about almost anything, preferring mundane topics like daily activities, personal interests, hobbies, or what they had read or seen on TV. This kind of small talk contributed to a slower pace in conversations. Often, care users spoke with the same two or three care staff members, allowing them to continue conversations from previous days, further contributing to the experience of a slower pace during video visits.

As I have shown, there was a discrepancy between clock time and perceived time. Even though the conversations were short, they were not generally perceived as rushed. One possible explanation for this discrepancy is how the digital homecare team conveyed presence during video visits.

6 From back-to-face to face-to-face

Face-to-face meetings have been described as central in social work, care work and homecare. The implementation of digital technologies has often been viewed as a threat to care quality, with concerns that both the time spent with each care user and human contact will decrease (cf. Aanesen et al., 2011). Similar concerns have been raised for video visits, even though they allow care staff and care users to meet face-to-face over screens (cf. Grünenberg et al., 2022), as they lack in-person interaction and touch. The screen is often seen as a constraint (Oh et al., 2018). However, despite video visits being *mediated encounters* (LaMendola, 2010; Oh et al., 2018), the 'mediated presence' communicated by the digital homecare team during these visits was experienced as stronger than during home visits. In this section, I will explore how this *mediated presence* was performed by the digital homecare team and its connection to the perception of time.

6.1 Digital homecare team

Most members of the digital homecare team had previously worked in physical homecare, and many had performed home visits. Interestingly, they did not describe their previous work as being in line with ideals such as continuity, stability, and having time to attend to each care user's individual needs, as highlighted in research (cf. Hale et al., 2010; Aanesen et al., 2021). Instead, physical homecare was often described as providing 'back-to-face' meetings because care staff had to perform practical tasks while talking: "you could talk to them while you were doing the dishes. But it was not quite the same thing" (Katarina). The same interviewee described the differences between the meetings in the two settings like this:

> Because then (during home visits), I had my back to (the care users), which made it completely different. Here (during video visits), you sit opposite each other without stress, in peace and quiet, and talk to the (care users). Home visits were more stressful "Oh now I must be at the next one (care user) in five minutes", for example. So, there is less stress (during video visits). (Katarina)

Another interviewee described the differences between the meetings in the two different settings like this:

> Yes, it becomes completely different when you sit down and have a conversation (during video visits) (…) I hope the care users feel that I can be more present. During home visits, you often do not have time to sit down and meet the person because you are running around, making the bed, and washing the dishes quickly. Of course, we talk at the same time, but they end up talking to my back. (Filippa)

It seems that the digital homecare team experienced a shift from 'back-to-face' interactions during home visits to 'face-to-face' interactions during video visits. As the quote illustrates, the interviewee felt they could be more present during video visits. They suddenly had time to make eye contact, look at each other, listen, and smile, using both verbal and nonverbal cues to show presence (cf. Kreijns et al., 2022):

> Just like you and me, eye contact allows you to see into a person's life. You can see where they are sitting, maybe some paintings behind them, or that they are in the kitchen. You quickly form an idea about the person based on their surroundings and way of talking. This creates a close contact quickly, often leading to a friendship for many of them. Of course, every (care user) is different. (Maja)

The digital homecare team used the screen to get to know care users and make them feel seen, quickly building strong relationships. The term 'friendship' indicates such closeness. It was not just about 'being there' for the care user, but more about 'being with' the care user, listening, being authentic, and giving of oneself (cf. Fredriksson, 1999: 1171). Initially, the digital homecare team faced scepticism about how video visits would affect care users and the quality of care. When asked what surprised them the most, Kim responded:

> It is probably the scepticism about stopping the physical visits. The concern—what effects does it have on the care user? Does it have positive or negative effects? People have thought that, yes, but if we remove a physical visit they will end up with less human contact. But the feedback from care users has been the opposite. They feel that we are now present even though we are not in the same room. So that is probably the biggest surprise in the whole project. That it has actually become more personal and [led to] better meetings. (Kim)

The intentions behind video visits were to increase efficiency in homecare and to expand care users' options, flexibility, and independence (cf. also Rosenlund et al., 2023). However, as the quote shows, the biggest surprise of video visits was that meetings with care users became more personal and better. Hence, the physical distance gave rise to new forms of 'unexpected intimacy' (Andersen et al., 2018: 58), which was a positive unintended outcome. In fact, the interviewee noted that care users felt as if they had more human contact since adopting video visits. While home visits did not allow for the same availability and conversations (cf. Kreijns et al., 2022), 'physical meetings' and 'being in the same room' were still often associated with closeness. One interviewee said: "it (video visit) becomes like a physical meeting in the end. At first, when I called, I was a little nervous. And you see yourself there (on the screen) (…) But now, no, it is like meeting in person with the image" (Lukas). There is an underlying assumption that home visits are more authentic and real (cf. Aanesen et al., 2011; Grünenberg et al., 2022). The digital homecare team had to challenge both their own and others' preconceptions about the importance of meeting in person. Video visits, even though they were *mediated encounters* (cf. LaMendola, 2010), allowed for a higher level of presence—a mediated presence—largely based on *being with* care users.

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6.2 Care users

Care users were generally satisfied with both physical and digital homecare, appreciating care staff in both settings. For instance, one care user referred to the physical homecare staff as her 'family', indicating a strong sense of closeness but also a feeling of loneliness. While interviewees did not explicitly mention talking 'back-to-face' with care staff in physical homecare, they described the constant time pressure faced by care staff, aligning with previous research (Tufte, 2013; Bergschöld, 2018; Ernsth Bravell et al., 2021; Strandell, 2022; Voie et al., 2024; Palmqvist, 2022; Jönson et al., 2024). One care user noted: "it felt very safe with physical homecare, but there was time pressure" (Belle). Another explained: "3–4 years ago, only during that time it has changed. This stress. They showed me their list. They came here at 6:30 p.m. and had 13 care users to see before 10 p.m., riding a bike" (Rose). Care staff often had to rush to the next care user, especially during busy times like evenings or crises. Similar to the digital homecare team's description of video visits, care users found video visits offered a different type of encounter compared to home visits. They felt that video visits provided a face-to-face experience:

> No, but it is still some kind of eye-to-eye, face-to-face. This certainly means something. I do not need to have them next to me, but it still feels good that I see them, that we can look at each other. I think that is great. Now I have the advantage that I do not have to have help with cooking or the shower and things like that. So, this works for me, but it does not work for everyone (Leona).

Video visits had their limitations, as they provided *mediated encounters* (cf. LaMendola, 2010). Practical tasks, such as taking out the garbage, could not be performed via the screen. This type of *being there* for the care user could not be offered by the digital homecare team. However, care users described the conversations during video visits as stimulating and pleasant: "the conversations themselves are a very positive element in my everyday life. We get along very well and laugh at the same things. It is stimulating. They are good at talking. I am not taciturn, as you can tell" (Gilbert). This indicates that they found mutual interests to discuss and laugh about, enhancing the sense of presence and that the digital homecare team was *being with* the care user during video visits:

> I have also had several interesting conversations with the ones who call (care staff). It is also a bit interesting because they are different people. And it is quite important that they are willing to share of themselves so that it can be a pleasant conversation. Sometimes you can discover that you have something in common as well, and then they can talk about it (Ottilia).

The digital homecare team's willingness to share about themselves and make an effort to get to know the care users fostered a sense of *being with* the care users. Care users also described this sharing and effort as mutual. Besides having face-to-face conversations, care users found that video visits allowed them to show care staff their hobbies, meals, and purchases, enhancing the overall experience, as previous studies on screen-based communication in social work has indicated (Andersen et al., 2018; Mishna et al., 2021): "I quite like to do needlework, and on some occasions, I had told them that I had been to a group for needlework. Then they asked what I did, and I showed them" (Tilde).

Care users also felt that the digital homecare team could show presence and *being there* by attending to other needs. For example, care staff could assess the care users' health via the

screen, ensuring they were doing well. This added another layer of support and connection during video visits:

> X, who is the one who usually calls me, usually asks a few questions. You can also see quite well how things are, at least if you are like X, who is an old, experienced assistant nurse and who kind of looks at the patient and gets an idea of how it is today, before you have even asked. (Duni)

Another care user had a similar experience:

> I also appreciate that there is a picture, because it can happen that I do not see myself and that I become very ill. My mouth keeps talking, but then maybe the care staff looks at me and says, "now he has this and that." So, I like that—that I am seen. (Gilbert)

The interviewee liked the fact that he felt seen on the screen. Hence, the care users did not only experience the video visits as stimulating and pleasant conversations, but also described the medical competence of the care staff as important. Another interviewee said that she felt taken care of, even through the digital medium: "they are supportive and there for me. I feel it. That they want you well and take care of you, kind of digitally" (Leona). This means that the 'mediated presence' that the care users experienced during video visits included both *being there for* and *being with* the care users, even though *being with* care users was most common.

7 Conclusions and discussion

Several scholars (Rosa & Scheuerman, 2009; Sharma, 2014) have criticised the assumption that our contemporary lives are getting faster, particularly due to the use of various digital technologies that tend to accelerate processes and increase speed. Video visit technology influences actual time within homecare by overcoming spatiotemporal distances and reducing travel time, thus contributing to technical acceleration (cf. Rosa, 2013). Interestingly, video visits did not automatically lead to perceptions of *accelerated time* for either the digital homecare team or their care users. In fact, the opposite occurred. They experienced a slowdown in the pace of conversations between care staff and care users during video visits and in the passage of time. Previous research has often described homecare and time scarcity as a dilemma (Tufte, 2013; Strandell, 2022), where tensions arise between process time and clock time (Davies, 1994). However, this article has shown that video visits did not evoke such dilemmas or tensions.

In times of austerity and constant welfare cutbacks (Cummins, 2018), the example of video visits in homecare stands out. Previous research has often associated digital technologies with a neoliberal agenda and time efficiency (cf. Strandell, 2022). However, this article explores video visits outside the paradigm of austerity and welfare cutbacks. Although the municipality and the digital homecare team aimed to increase time efficiency by implementing video visits to address future staff shortages, it can also be seen as a welfare investment during times of austerity, even if the municipality did not frame it that way. This article indicates that time efficiency and the perception of time do not necessarily have to be in opposition. In fact, during video visits, the duration and pace of time were perceived differently, and the visits were seen as something extra, adding value for most of the care users who were interviewed.

In social work research, several challenges have been identified in screen-mediated communication (cf. Pollack, 2008; Henze-Pedersen & Kirkegaard, 2025). Two major concerns raised are that face-to-face meetings will be replaced by digital ones (see Henze-Pedersen & Kirkegaard, 2025, for an overview) and that screens limit meetings (Løberg & Egeland, 2021).

Research has also discussed the fear that care staff will be replaced by digital technologies, leading to the dehumanisation of homecare (cf. Aanesen et al., 2011; Milligan et al., 2011; Pors, 2012). There are reasons to question this assumption and the idea that meeting in person and being in the same room can be equated with closeness, presence, and being seen. This article shows that the experience shifted from 'back-to-face' meetings during home visits to 'face-to-face' meetings during video visits. Contrary to concerns, video visits were associated with warmth rather than coldness (cf. Aanesen et al., 2011; Milligan et al., 2011; Pors, 2012). However, it was not the digital technology itself that was associated with warmth, but how the digital homecare team conducted the video visits, their ability to show presence, and their effective use of the screen that seemed to contribute to the overall positive experience.

Video visits allow the digital homecare team to show what can be referred to as a 'mediated presence'. Since the interaction occurs via a screen, they cannot provide the same level of *being there* for care users as physical homecare staff can during home visits. The digital homecare team cannot touch the care users, help them put on support socks, or take out the rubbish. However, the digital homecare team can use their medical expertise to assess whether care users appear to be feeling well. The fact that they know the care users and often have recurring conversations seems to make it easier to show that they are *being with* the care users. In fact, what distinguishes video visits from home visits is their ability to *be with* care users, which is challenging to demonstrate during home visits due to various disruptions, practical tasks, and time scarcity. In line with previous studies on video visits to placed children (Andersen et al., 2018) and social work during the COVID-19 pandemic (Mishna et al., 2021) the physical distance brought new forms of 'unexpected intimacy' (Andersen et al., 2018: 58) in digital homecare by increasing casual conversations and small talk, which made it easier to get to know each other. Even though not framed by the digital homecare team as 'social contact', but more like a part of every video visit, it can be discussed if video visits also reshape 'social contact' within homecare. This article also shows that feeling seen and cared for is important for care users, regardless of the setting. If physical homecare makes more room for face-to-face meetings and *being with* care users, the overall experience of quality of home visits might increase. Making eye contact, talking about mundane things, joking, laughing together, and following up on conversations seem to contribute to a slowdown in conversations and a sense of presence. This finding is relevant to other social work settings as well.

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