DIGITAL CARE, HUMAN FUTURE

MAKING TECHNOLOGY AND AI WORK FOR EUROPEAN OLDER PERSONS CARE



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DIGITAL CARE, HUMAN FUTURE
MAKING TECHNOLOGY AND AI WORK FOR EUROPEAN OLDER PERSONS CARE

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The European Ageing Network (EAN) gathers more than 13,000 older persons care providers across Europe. Members consist of all types of organisations and individuals active in the field of ageing and include all types of ownership, such as for-profit, not-for-profit, and public organisations. These member organisations work to improve the quality of life for older persons by providing high-quality housing, care and support services.

EAN is a truly pan-European organisation, present in 30 European countries. It does not stand alone in pursuing its vision, values, and mission, as it is a member of the Global Ageing Network (GAN), a worldwide network based in Washington

D.C. EAN and GAN bring together experts from around the world, lead educational initiatives, and provide a platform for innovative ideas in senior care. They pave the way to improve practices in the care of older persons, enabling them to live healthier, stronger, and more independent lives.

The members of the EAN network serve millions of older persons in Europe. Longevity is one of the greatest achievements of modern societies, and European citizens are living longer than ever before.

This trend is expected to continue due to unprecedented medical advances and improved living standards. However, combined with low birth rates, this will require significant changes to the structure of European society, affecting the economy, social protection, healthcare systems, the labour market, and many other aspects of life.

The European Ageing Network supports care providers in responding to these changes, including through the responsible use of digital technologies and artificial intelligence. These tools can help improve quality and safety, support autonomy, reduce administrative workload and strengthen communication. Their value depends on how well they meet the needs of older people and the professionals who support them. Investment in technology must therefore be accompanied by investment in skills, organisational change and implementation.

Through its Working Group Digitalisation, EAN brings together representatives of care providers, sector organisations and technology-related organisations to exchange experience, examine emerging developments and identify practical lessons. Building on EAN's first digitalisation report, published in 2024, this report draws on member research, working group discussions, practical examples and European policy developments. It explores how providers can select, implement, govern and scale technologies that deliver demonstrable benefits for care. Throughout this work, EAN's guiding principle remains clear: technology should strengthen human care, preserving dignity, autonomy, privacy and meaningful human relationships.



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EXECUTIVE SUMMARY

European older persons care is moving from digitalisation towards intelligent, data-driven care. The challenge is how to select, implement and govern technologies that demonstrably improve care, support the workforce and preserve human relationships. The central conclusion of this report is that technological progress must be matched by investment in people, organisational change and the capacity to turn useful innovation into everyday care.

Key findings and conclusions

Digital maturity differs, but members share clear care priorities. The 2025 EAN member survey identifies a consistent direction: better quality and safety, greater autonomy and quality of life, reduced staff workload and stronger communication with families. Administrative and communication tools are relatively established, while advanced monitoring, telemedicine, wearables and AI are adopted less consistently. Members identified funding, skills, technical complexity and regulation as barriers, alongside concerns about reliability, privacy and the preservation of human contact.

AI can change both professional work and the organisation of care. Four roles are particularly relevant: reducing repetitive work, supporting professional decisions, anticipating changing needs and enabling new models of care. Beyond documentation and administration, AI may support earlier intervention, more individualised supervision and support between home-care visits. These possibilities depend on a care service being able to interpret information and respond: an alert creates value only when it leads to appropriate action, and an AI-generated recommendation requires professional judgement.

Implementation requires investment in the workforce and the organisation. Digitalisation involves changes to responsibilities, routines and the allocation of professional time. Its costs extend beyond purchasing a product to integration, training, maintenance and ongoing support. Upskilling and reskilling are essential to this transformation. Technology should make work more manageable and release capacity for direct care; additional interfaces, duplicate records and poorly managed alerts can undermine that purpose.

Connected information, security and clear responsibility underpin dependable care. Interoperability helps information follow the older person across services and supports more advanced uses of AI. Cybersecurity and continuity arrangements protect the delivery of care when systems fail or are disrupted. AI governance and preparation for European AI and health-data frameworks therefore belong within organisational planning, alongside decisions about systems and suppliers.

The value of technology lies in what changes for people. Outcomes include autonomy, safety, quality of life, professional workload and the experience of care. Member-reported examples illustrate practical benefits and implementation challenges; they also show why different technologies need to be assessed against their intended purpose. Successful implementation requires evidence of useful results and acceptance in everyday practice. Dignity, privacy and human relationships remain guiding principles, consistent with EAN's Position Paper. [1]

Human contact is not an inefficiency.

Technology can appropriately automate administrative and repetitive tasks, improve access to information and support professionals. It should not progressively replace the relationships, reassurance, recognition and personal attention that are fundamental to good older persons care. Monitoring and AI-supported services must respect dignity, privacy, autonomy and meaningful choice. Older people who cannot or do not wish to use digital channels must not receive poorer access to care.

Automate the task where appropriate; preserve the relationship where it matters.

Looking towards 2030, EAN's vision is of more personalised, preventive and connected care in which technology strengthens rather than diminishes the human dimension of care. Relevant information should follow the older person across services; professionals should have the skills and confidence to use and question digital systems; proven technologies should be easier to integrate into everyday care; and AI-supported services should increase autonomy and professional capacity while maintaining human responsibility.

The demographic and workforce pressures facing European older persons care make this transformation increasingly important. Technology alone will not solve workforce shortages or rising demand for care. Used well, however, it can help Europe use limited human capacity more effectively and enable professionals to devote more of their time to the work for which people are indispensable.

The objective is not more technology.
The objective is better care, enabled by technology where it adds value.

Does digitalisation help older people live better lives and help professionals provide better care?

Six priorities for action

1. Define the care problem and the expected improvement. Establish what needs to change, who should benefit, and how success will be assessed before selecting a product. Compare technological options with changes to the care process itself.

2. Build implementation around the people who will use it. Involve care professionals, older people and families from the beginning. Plan training, support, responsibilities and changes to everyday work alongside

procurement. Check whether the solution reduces work or creates additional tasks, alerts and duplicate records.

3. Make data, integration and security part of the decision. Establish what information the solution needs, how it connects with existing systems, and who can access the data. Include cybersecurity, continuity of care, supplier support and the ability to retrieve data when assessing cost and suitability.

4. Introduce AI with clear responsibility and human oversight. Match checking and supervision to the use and its consequences. Professionals need to understand the limits of AI outputs and know when to question or override them. Establish the applicable legal responsibilities and preparation needed for the systems concerned.

5. Use pilots to make decisions about wider implementation. Record the starting position and agree outcomes before a pilot begins. Assess benefits alongside workload, acceptability, costs and unintended effects, then decide whether to scale, adapt or stop. Wider deployment requires a further assessment of staffing, infrastructure and support.

6. Share implementation experience that other providers can use. Record the problem addressed, the conditions required, the changes observed, and the difficulties encountered. Useful exchange explains how a solution works within a care organisation and what another provider would need to consider before adopting it.

EAN Vision 2030 — Digital Care That Remains Human Care

The leading vision of EAN is for older people to experience more personalised, preventive and connected care, with greater autonomy and meaningful human contact. Technology and AI should enable timely support and strengthen professionals' capacity to provide individual attention. Progress towards this vision means making useful innovation part of dependable everyday care, with dignity, choice and human relationships at its centre.

FOREWORD



Europe is ageing. The number of people who need care and support is increasing, while the number of professionals available to provide that care is becoming increasingly limited. At the same time, expectations are changing. Older people rightly expect to live independently for as long as possible, to have greater choice and control over their lives, and to receive high-quality, personalised care when they need it.

Technology cannot solve all these challenges. But I am convinced that we will not be able to address them without technology.

When the European Ageing Network published Accelerating the Digital Transition in 2024, our message was clear: older persons care in Europe needed to accelerate its digital transformation. We identified significant differences in digital maturity across countries and organisations, as well as barriers related to investment, skills, interoperability, evidence and strategy.

Only two years later, the discussion has already moved forward.

Artificial intelligence is developing at extraordinary speed. Digital monitoring, sensors, predictive technologies, telecare and connected data are creating possibilities that would have seemed unrealistic only a few years ago. The question is therefore no longer whether digitalisation will become part of older persons care. It already is.

The more important question today is: **how can we make technology truly work for care?**

This report attempts to provide some answers.

Our starting point is deliberately simple: **start with the care problem, not with the technology.** Innovation has value only when it improves the lives of older people, supports those who care for them, increases safety or autonomy, reduces unnecessary workload, or allows scarce professional capacity to be used more effectively.

This is particularly important when we talk about artificial intelligence. AI can help us with administration and documentation. It can support professional decision-making. It can help identify risks earlier and enable more preventive and personalised forms of care. These possibilities are significant and should not be underestimated. But neither should we overestimate them.

Care is, and must remain, fundamentally human. Technology can process information, recognise patterns and automate tasks. It cannot replace empathy, trust, reassurance, touch or the feeling that another human being genuinely cares about us.

That is why one of the most important messages of this report is also one of the simplest:

Human contact is not an inefficiency.

If technology saves a care professional thirty minutes of administrative work, our ambition should not automatically be to remove thirty minutes of human capacity. Wherever possible, we should transform this **digital dividend into a care dividend:** more time for people, more individual attention, better communication and ultimately better quality of life.

For the same reason, Europe must move beyond endless experimentation. We already have thousands of innovative projects and promising technologies. What we need now is stronger evidence about what works, better interoperability, investment in implementation and skills, and a much greater ability to bring successful solutions from pilots into everyday care.

We must also be prepared to stop using technologies that do not create sufficient value. Digitalisation is not a competition to introduce as many technologies as possible. Success should not be measured by the number of devices, applications or AI systems we deploy, but by their impact on people.

The European Ageing Network represents more than 13,000 care providers across Europe and brings together organisations operating in very different care systems and at very different stages of digital transformation. This diversity is one of our strengths. It allows us to learn from each other, share successes as well as failures, and help ensure that innovation is not limited to a small number of technologically advanced organisations or countries.

I would therefore like to thank the members of the EAN Working Group on Digitalisation and all EAN members and experts who contributed their experience, knowledge and examples to this report.

Our first report called on Europe to accelerate the digital transition.

With this second report, we are taking the next step.

We now need to make that transition work – for older people, for professionals, for care organisations and for society as a whole.

The future of older persons care will undoubtedly be more digital. It will increasingly use artificial intelligence. It will be more connected, predictive and personalised.

But above all, it must remain human.

Dr. Jiří Horecký, MSc., MBA
President & CEO
European Ageing Network

1.

INTRODUCTION: FROM DIGITAL TRANSITION TO INTELLIGENT CARE

Digitalisation is no longer a future ambition for European older persons care. Digital documentation, communication platforms, monitoring technologies, telecare and other digital solutions are already part of everyday care in many organisations. Artificial intelligence is now adding a new dimension, extending the potential of technology from digitalising existing processes towards automation, prediction, decision support and increasingly personalised care.

The first European Ageing Network (EAN) Working Group Digitalisation report, published in 2024, focused on accelerating this transition. It highlighted differences in digital maturity across Europe and the need for clearer vision, investment, interoperability, evidence and workforce skills. It also emphasised that digital transformation should empower older people and support professionals rather than become an objective in itself. [2]

Two years later, these foundations remain relevant, but the context has changed significantly. Artificial intelligence has moved rapidly into organisational practice and public debate. European policy and regulation around AI, health data and cybersecurity have developed substantially. Providers are facing an expanding market of digital solutions while continuing to operate under pressure from workforce shortages, rising costs and increasing demand for person-centred care.


Hospital symbol
Bacteria
111
Test tube
globe



This report therefore examines how organisations can select, implement, govern and scale technologies that create demonstrable value for older people, professionals and care systems.

It draws on the continuing work of the EAN Working Group Digitalisation, including research involving EAN members, discussions with members and experts, and practical examples contributed by organisations in different European countries. Together, these inputs identify providers' priorities, the challenges they encounter and the conditions that support successful implementation. The report introduces this experience along with published research and European policy and regulatory developments. The regulatory review reflects the position on 22 September 2026.

Throughout the report, technology is considered from the perspective of the problem it is intended to solve. The central principle is therefore simple:

Start with the care problem, not with the technology.

Artificial intelligence makes this discipline particularly important. AI can support documentation, planning, monitoring, prediction and professional decision-making, but its use also raises questions of reliability, transparency, responsibility and human oversight. At the same time, its potential depends on issues that are not primarily about AI: data quality, interoperability, cybersecurity, workforce competence, organisational change and trust.

EAN's position is that technological progress in older persons care must remain human-centred. New technologies and AI should support autonomy, dignity, safety and well-being and strengthen professional care rather than progressively replace the human relationships on which care depends. This approach is central to EAN's Position Paper of 30 October 2025. [1]

The ambition of this report is therefore not to predict which technologies will dominate older persons care. Technologies will continue to change too quickly for such a catalogue to remain useful for long. Instead, the report aims to provide a more durable framework for making better decisions about technology: what to use, why to use it, how to implement it responsibly and how to determine whether it has genuinely improved care.

2.

WHAT HAS CHANGED SINCE THE 2024 EAN REPORT

The 2024 EAN report addressed a sector in the process of digital transition. The central challenge was to accelerate adoption while addressing barriers such as limited strategic vision, investment, skills, evidence and interoperability. [2]

Those challenges have not disappeared. What has changed is the environment around them.

2.1 From digital tools to AI-supported care

The most visible development is the rapid expansion of artificial intelligence. Digitalisation traditionally focused largely on replacing analogue processes, connecting information and introducing individual technologies. AI extends this potential by enabling systems to generate and summarise information, recognise patterns, support decisions and anticipate needs.

This creates opportunities at several levels of older persons care. Administrative applications may reduce documentation and organisational workload. Analytical systems may support monitoring and earlier identification of risk. More advanced combinations of AI, sensors and connected data may contribute to a shift from reactive towards more preventive and predictive models of care.

The Working Group's 2025 discussions consequently described the emerging environment as a shift from digitalisation towards AI-supported care models, while recognising that providers increasingly need support to navigate AI rather than ICT alone.

Yet greater technological capability does not automatically create greater care value. AI can also generate inaccurate outputs, unnecessary alerts, additional work or inappropriate reliance on automated recommendations. The management question is therefore no longer only whether a technology works, but whether it improves the care process in which it is used.

2.2 Data, interoperability and governance have become strategic

A second shift concerns data. More advanced digital services and AI depend on the availability, quality and exchange of information. As organisations accumulate digital systems, fragmentation becomes increasingly visible: technologies may work individually while failing to communicate effectively with each other.

Interoperability is therefore moving from an IT concern towards a strategic issue for care organisations. The Working Group's discussions identified it as a major barrier and called for interoperability to become the rule rather than the exception.

At the same time, European developments around health data, AI and cybersecurity are changing the governance environment in which providers operate. The implications of the European Health Data Space, the EU AI Act and increasing cybersecurity requirements are addressed later in this report. Their combined significance is already clear: digitalisation can no longer be treated primarily as the acquisition of technology. It increasingly requires decisions about data governance, integration, accountability, risk and organisational resilience.

2.3 From adoption to implementation

Perhaps the most important change is less technological.

European older persons care does not lack innovative ideas or pilots. The harder challenge is embedding useful technologies in everyday practice and demonstrating that they create sustainable value. The Working Group's discussions called for greater emphasis on implementation and learning from pilots.

The distinction matters. A successful demonstration proves that a technology can function. A successful implementation requires it to work with real residents, professionals, workflows, data and infrastructure over time. Scaling adds another test: whether benefits remain when the solution moves beyond the original team or setting.

This places greater emphasis on change management, workforce involvement, integration and evaluation. It also requires organisations to define success before implementation rather than after it.

3.

WHAT EAN MEMBERS TELL US: DIGITALISATION AND AI IN EUROPEAN OLDER PERSONS CARE

To better understand the current state of digitalisation and the emerging role of artificial intelligence in older persons care, the EAN Working Group on Digitalisation conducted a survey among organisations across Europe in September 2025.

Respondents represented organisations from the United Kingdom, including Scotland, Spain, Italy, the Netherlands, Germany, France, Lithuania and Slovakia. They included residential and home care providers, membership and advocacy organisations, day care services, NGOs and cultural and educational initiatives working with older people. They also varied considerably in size and in the number of older people they serve. The findings describe the experiences and priorities of participating organisations within the EAN community.

3.1 Digitalisation is progressing, but at very different speeds

The survey reveals varying levels of digital maturity among respondents. Administrative and communication technologies are already widely used. Databases, digital case management, electronic communication, video calls and online platforms have become an increasingly common part of everyday operations.

More advanced technologies are adopted less consistently. Smart-home and Internet of Things (IoT) solutions, telemedicine, wearables, social robotics, AI-based forecasting and automation are present, but their use varies considerably between organisations. Artificial intelligence in particular remains predominantly at an early or pilot stage.

This uneven development is important. The next phase of digitalisation in older persons care needs to reflect differences in organisations' digital maturity, infrastructure, skills and resources.

3.2 The value of technology is increasingly linked to care outcomes and workforce sustainability

Respondents identified several recurring benefits of digital technologies: improvements in quality of care, enhanced resident safety, reduced professional workload and better communication with families. Examples included early detection and safety monitoring, automation of routine work, fall detection, medication management and digital communication platforms.

These findings show that organisations expect digitalisation to contribute directly to resident safety and quality of life while supporting a workforce under growing pressure. Operational efficiency matters because of the difference it can make to care and professional capacity.

The priorities identified for the next two to three years reinforce this direction: supporting resident autonomy and quality of life, reducing staff burden and turnover, improving safety and monitoring, developing AI-integrated models of care and streamlining administrative workflows.

The survey also identifies conditions affecting providers' ability to achieve these benefits. Cost and funding were prominent barriers, alongside staff resistance and digital literacy gaps, technical complexity, integration difficulties and legislative or compliance questions. Respondents described

support from EU programmes, government and charitable funding, as well as investment from their own organisations. Partnerships with universities, technology companies, care networks and pharmacies were also part of their experience.

3.3 Expectations of AI are high, but so are the concerns

Respondents showed very different levels of familiarity with artificial intelligence. Some organisations reported little or no familiarity, while others were already actively experimenting with or using AI-enabled solutions.

Desired applications included predictive health monitoring, such as identifying fall risk or cognitive decline; automation of documentation and reporting; personalised care planning; staff scheduling and workload optimisation; and virtual companions for older people.

At the same time, respondents raised concerns about data privacy and security, the reliability and accuracy of AI systems, costs, over-dependence on technology and the potential loss of human contact.

This combination of expectations and concerns points to a central challenge: introducing AI requires decisions about how care is organised, how professionals are supported and how responsibility and quality are maintained.

3.4 Skills and implementation capacity may become the decisive factor

Digital literacy remains a major barrier. Training is inconsistent: some organisations reported occasional or rare provision, while others reported none.

Respondents identified a need for practical training in digital literacy, AI use cases in care settings, ethics, data privacy and change management. They also sought funding guidance, technical support and maintenance.

Their implementation experience provides a consistent message: successful digital projects tend to start small, involve care professionals from the beginning, address an identifiable resident or workforce need and integrate gradually into existing workflows.

The survey gives this message concrete form through six practice examples: Malina Portal, Teia Care, Upmeet, Navel Social Robot, Care Connector and Perpetuo Socorro Residence. They cover documentation, monitoring, meeting administration, social interaction, telecare and the introduction of multiple digital systems. Appendix A showcases these examples along with the outcomes and lessons reported by members; Chapter 10 considers what they mean for implementation.

For providers, a useful starting question is therefore:

Which care or workforce problem are we trying to solve, and what evidence will tell us that technology has helped?

4.

FROM TECHNOLOGY TO TRANSFORMATION: CHOOSING TECHNOLOGY FOR THE CARE PROBLEM

The growing number of technologies available to older persons care makes the selection process more demanding. Providers have more options than ever before, but choosing the right technology is becoming more difficult. Digital documentation, sensors, wearables, telecare, robotics and AI may all create value, but only when they address a relevant problem and fit the care environment in which they are used.

Start with the care problem, not with the technology.

This principle emerged repeatedly from the work of the EAN Working Group. The initial idea of developing a decision tree for AI gradually evolved into a broader implementation approach. By the end of 2025, the Working Group described the decision tree not as an objective in itself, but as an instrument for determining why technology should be used, which problem it should solve, when it should be implemented or scaled, and when it should be stopped.

4.1 Define the value before choosing the technology

Care organisations face very different problems. Technology may be considered because professionals spend excessive time on documentation, information is fragmented, deterioration is recognised too late, residents need greater support for independence, safety risks are difficult to manage

or communication between professionals, older people and families is insufficient. These problems should not automatically lead to the same technological response. The first management question should be:

What should improve after implementation?

Expected value may concern quality and safety, autonomy and quality of life, professional workload, continuity of care, communication or organisational efficiency. Defining this value before selecting a solution provides a basis for later evaluation and helps prevent technology from becoming an objective in itself.

Table 1 connects common care challenges with possible technology responses and the outcomes a provider should assess. Select the row that matches the problem, define the expected improvement and record the starting position before testing a solution.

Table 1. Connecting care challenges with technology and evaluation

Care challenge	Technology response	Expected value	What must be demonstrated
Falls and safety	Sensors, radar, wearables, AI/video analytics	Support prevention, earlier detection or faster response, depending on the solution	For prevention: fall frequency and severity. For detection: missed events, response time and false alarms.
Documentation burden	Voice/AI documentation and automation	More time for direct care	Net time saved, including checking and corrections; documentation quality.
Workforce shortage	Automation, scheduling and robotics	Reduced workload and better allocation of staff time	Workload, time released, staff acceptance and effects on care.
Clinical deterioration	Sensors, wearables and predictive analytics	Earlier identification and intervention	Detection sensitivity, actionable alerts, false alarms and care outcomes.
Independence	Smart-home and assistive technologies	Greater autonomy and support for ageing in place	Independence in everyday activities and quality of life.

Care challenge	Technology response	Expected value	What must be demonstrated
Social isolation	Communication platforms and social/ assistive robots	Engagement and connection	Meaningful interaction, acceptance and the person's experience of connection.
Medication safety	Digital medication management and decision support	Fewer errors	Medication incidents, usability and effects on the medication workflow.
Coordination	Interoperable care platforms and telecare	Continuity across services	Information availability, duplicate work and continuity during transitions.

The table is a planning tool: expected value describes the intended benefit, to be tested in the care setting. In particular, detecting a fall and preventing one require different outcome measures. Associations can use the same structure to collect comparable implementation experiences from members.

Technology can also operate at different levels of transformation. Some solutions optimise existing work: they reduce administration, simplify communication or automate repetitive tasks. Others may change how care itself is organised, for example by enabling earlier intervention, remote support or more predictive approaches.

Both can create substantial value. Transformation should not be preferred simply because it appears more innovative.

4.2 A practical decision framework

Based on the work of the Working Group and the evidence considered throughout this report, EAN proposes a practical sequence for technology decisions:

CARE NEED → EXPECTED VALUE → USERS → DATA → TECHNOLOGY → INTEGRATION → RISK → EVIDENCE → PILOT → KPI → SCALE / STOP

Technology appears only after the problem, expected value, users and data have been considered. Key performance indicators (KPIs), their baseline and the thresholds for decisions must be agreed before the pilot starts; the KPI stage represents assessment of the results, not the first definition of success.

The framework should not become another administrative checklist. Its purpose is to create decision discipline. Who will use or experience the solution? What information does it require? Can it integrate with existing systems? What risks does it create? What evidence supports the expected benefit? What should be tested before wider implementation? And which outcomes will determine whether the organisation scales, adapts or stops?

The final element is particularly important. Organisations need the ability to stop technologies that fail to create sufficient value, even after time and money have already been invested. A well-designed pilot therefore tests a decision, not merely a product.

Practice illustration: fall prevention

Fall prevention illustrates why starting with technology can lead to the wrong question. Technologies in this field range from risk-assessment tools and mobility monitoring to environmental sensors and fall-detection systems. Yet these interventions operate at different points in the care pathway.

A more useful sequence is:

ASSESS RISK → PREDICT → PREVENT → DETECT → RESPOND → LEARN

The distinction matters because detecting a fall is not the same as preventing one. A provider whose main problem is delayed response may need a different solution from one trying to identify increasing instability before a fall occurs.

This illustration draws on work of the Czech Association of Social Services Providers (APSS) expert group on fall prevention. Appendix B presents

an English adaptation of Marek Šoltys's technology overview of 25 February 2026, covering assistive technologies for safety and monitoring, with a focus on falls management. It includes technology categories and named examples across different stages of the pathway.

The broader lesson applies well beyond falls. Technology should be selected according to **where in the care pathway an intervention is needed and what outcome it is expected to change.**

That decision becomes more complex when the technology includes artificial intelligence.





5.

ARTIFICIAL INTELLIGENCE IN OLDER PERSONS CARE: FROM AUTOMATION TO TRANSFORMATION

Artificial intelligence has rapidly moved from a specialist technology topic to a practical question for older persons care organisations. It can affect how professionals document care, interpret information, organise their work and respond to changing needs. Its significance therefore extends beyond the introduction of another digital tool.

The 2025 EAN survey reflects this transition. Some participating organisations had little experience of AI, while others were already experimenting with or using AI-enabled solutions. Respondents identified concrete areas in which they expect AI to create value: predictive health monitoring, documentation and reporting, personalised care planning, workforce scheduling and virtual companionship.

For providers, the central question is:

What should AI do for older people, care professionals and care organisations, and where should it not be used?

Answering it requires an understanding of the different roles AI can perform, the changes each role brings to care and the conditions for responsible use.

5.1 Four roles for AI in older persons care

1. AI that reduces work

Some of the most accessible applications help professionals complete existing tasks. Examples include speech-to-text documentation, summaries, draft

reports, meeting transcription, administrative assistance and scheduling. The intended benefit is to reduce time spent on routine work and make more professional capacity available for care.

The Upmeet example in the EAN survey makes this role tangible: the respondent described an AI meeting assistant that reduced administrative burden and improved efficiency. For a provider considering a similar use, the practical question is how much work remains once the initial output has been generated.

A draft care note, for example, still needs to be checked for accuracy, omissions and whether it reflects what happened. Producing a plausible draft quickly is useful only if checking and correcting it does not create more work than it saves.

2. AI that supports decisions

A second role is to help professionals interpret information. AI may highlight patterns in care records, draw attention to changes in mobility or behaviour, support medication review or help a team prioritise attention. Its purpose is to bring useful information into professional decision-making.

Care decisions also depend on personal preferences, cognition, family circumstances, frailty and knowledge of the individual. These may be incompletely represented in the data.

AI may identify a pattern; the professional must still understand what it means for the person.

In practice, a provider needs to establish who reviews a recommendation, what other information they should consider and when they should seek further assessment. The recommendation must reach someone with the knowledge and authority to act on it.

3. AI that anticipates needs

Predictive applications aim to recognise changes before deterioration or an adverse event becomes obvious. Information from care documentation, sensors and wearables may help identify changes in mobility, sleep, activity or behaviour. EAN survey respondents expressed interest in applications concerning fall risk and cognitive decline.

The potential change in care can be expressed as:

DATA → CHANGE DETECTED → RISK REVIEWED
→ APPROPRIATE EARLIER INTERVENTION

For example, if a system flags a change in an older person's usual activity, the care pathway must specify who reviews the alert, how they check its relevance and what action may follow. This is an illustrative workflow; an alert is not, by itself, a diagnosis or proof that an adverse event will occur.

Prediction creates value when information is reliable enough for its intended use, reaches the appropriate professional and supports an appropriate response. False alerts can add work, while missed alerts can create false reassurance. These risks make the response pathway an essential part of the AI application.

4. AI that enables new models of care

The longer-term potential of AI concerns how care is organised. Combined with remote monitoring, telecare and information shared across services, it may support more individualised supervision and earlier responses to changing needs.

In home and community care, this could help teams support people between visits and decide when additional contact is needed. In residential care, it could help teams review whether the timing and intensity of support still match individual needs. These are possibilities to test within a defined care model, with clear responsibility and arrangements for human contact.

The Care Connector contribution from Scotland illustrates this direction: the EAN survey described a pilot combining AI and telecare and identified governance among the barriers. It shows why a new care model depends on relationships between services, responsibilities and workflows as well as on the technology.

This is the distinction between optimisation and transformation. Optimisation makes an existing task easier; transformation changes how support is planned and delivered. A provider needs to explain what will change for the older person and the team before deciding which ambition is appropriate.

5.2 AI should augment human care, not displace it

AI should help professionals devote their attention to the people they support. Automated reminders, monitoring and conversational tools can have useful roles, but their introduction should be considered alongside their effects on choice, autonomy and human contact. EAN's Position Paper places these values at the centre of responsible AI use. [1]

The survey's Navel Social Robot example makes the distinction clear: the respondent reported greater resident engagement, with limited effects on staff workload. An application intended to provide stimulation should be assessed for that purpose, rather than assumed to release staffing capacity.

For implementation, the principle is:

Automate the task where appropriate, preserve the relationship where it matters.

Teams should agree how any time released will be used and review older people's experience of the change. Chapter 9 develops the implications for person-centred care.

5.3 Trust is an implementation requirement

Residents, families and professionals need to understand how AI is used and how concerns will be addressed. The EAN survey identifies privacy, reliability, over-dependence and the loss of human contact among members' concerns. Trust therefore needs to be built into the introduction of a system.

A provider should be able to explain, in language appropriate to the people affected:

- What does the system do, and what information does it use?
- What does it not know, and what are its known limitations?
- Who checks its output, and who makes the resulting decision?
- How can a resident, family member or professional question a result?
- What happens if the system is wrong or unavailable?

For staff, these answers should translate into instructions for everyday use. For older people and families, they should make clear how the technology affects care and whom to contact. Feedback and incidents should inform changes to the system or its use.

5.4 AI literacy is becoming a management responsibility

Staff need enough understanding to use AI within their role, recognise its limits and know when an output needs verification. Learning should be part of implementation planning, with time to practise and access to support. The relevant legal requirement is explained in Chapter 6; the wider workforce strategy is addressed in Chapter 8.

A practical training model should distinguish four groups:

- **All staff:** basic understanding of AI, privacy, approved tools, limitations and safe use.
- **Regular users:** using the specific application, checking outputs, recognising errors and escalating concerns.

- **Managers:** selecting use cases, procurement, effects on work, responsibility and evaluation.
- **Specialist or responsible roles:** data governance, cybersecurity, regulatory requirements, performance monitoring and supplier management.

For a documentation tool, training should include checking a plausible but incorrect draft. For a monitoring tool, it should include responding to false, missed or unclear alerts. Associations can help members by sharing such exercises and organising learning around common care applications.

The four roles described in this chapter help providers decide what they want AI to change in care. Table 1 in Chapter 4 connects those aims with outcome measures; Chapter 10 explains how to evaluate a pilot and decide on wider implementation.

6.

THE EU AI ACT: WHAT IT MEANS FOR OLDER PERSONS CARE

For a care organisation, the immediate task is to understand which AI systems it uses, what decisions they influence and who is responsible for them. This includes AI in recruitment and administration as well as applications used directly in care. The practical recommendations below help organisations organise this work; the legal obligations depend on the system, its use and the organisation's role.

The EU AI Act (Regulation (EU) 2024/1689) provides a common EU framework for artificial intelligence. It has applied progressively since its entry into force in August 2024 and was amended in 2026, including by the Digital Omnibus on AI. Practical implementation also involves national competent authorities, European guidance and other legal requirements applicable to the service. EAN members operate in different jurisdictions, including outside the EU, so the Act's applicability must be established for the organisation concerned. A shared European framework therefore needs to be translated into action in the relevant country and care setting. [3]

6.1 Which uses of AI need attention?

Start with a simple overview of the AI systems already used or being considered. Include AI functions embedded in existing software and AI tools that staff may be using informally. For each system, record its purpose, supplier, people affected, data used and the manager responsible.

The purpose matters. A tool that drafts meeting notes and a system that filters job applicants raise different questions. Certain AI systems used in employment, worker management and access to self-employment are expressly addressed in Annex III of the Act. A system is not automatically high-risk simply because it is used in older persons care: its intended purpose and the classification criteria in the Act determine whether it falls within the high-risk category.

The organisation's role matters. A care organisation using an AI system supplied by another organisation will commonly be a deployer under the Act. The legal term provider generally refers to the organisation that develops an AI system or has it developed and places it on the market or puts it into service under its own name or trademark. In certain circumstances, substantially modifying a system, changing its intended purpose or placing it under the organisation's own name or trademark can change the organisation's role and the responsibilities that follow.

A useful next step is to ask the supplier for a written explanation of the system's intended purpose and classification, and of the responsibilities of each party. Uses with potentially significant consequences for older people, staff or access to services deserve closer review with appropriate legal, clinical, care, data-protection or technical expertise.

6.2 What can a care organisation do now?

Four practical steps make the legal review useful in everyday work.

- **Assign responsibility.** Identify who approves a system's use, who reviews outputs affecting important decisions and who handles errors, incidents or concerns. Keep a record of the action required for each system.
- **Support AI literacy.** Explain what information may be entered into AI systems, when outputs need to be checked and where staff can obtain help. Article 4, as amended in 2026, requires providers and deployers to take measures to **support the development of AI literacy** among staff and other persons operating or using AI systems on their behalf. The

measures should take account of their knowledge, experience, education and training, the context in which the systems are used and the people affected. The amended provision expressly states that this does not require an organisation to guarantee a specific level of AI literacy for every individual.

- **Check supplier arrangements.** Obtain clear information about the system's intended purpose, limitations, data handling, human oversight, updates and support. Establish how problems will be reported and how essential work will continue if the system is unavailable. These are practical procurement and governance safeguards that should be adapted to the setting.
- **Make AI use understandable.** Where an AI system interacts directly with residents, families or other individuals, establish which transparency obligations apply and how they are implemented. Article 50 includes obligations concerning direct interaction with AI as well as AI-generated or manipulated content, emotion-recognition and biometric-categorisation systems and deepfakes. The applicable obligation and responsible party depend on the type of system and use: some duties fall on providers and others on deployers.

6.3 Which deadlines affect planning?

The position below reflects the rules **as of 22 September 2026**, including the amendments introduced by the Digital Omnibus on AI.

Already applicable: the definitions, prohibitions and AI-literacy provisions have applied since 2 February 2025; governance provisions and obligations concerning general-purpose AI models have applied since 2 August 2025; and the Article 50 transparency requirements generally apply from 2 August 2026. Organisations therefore need to review current uses against the requirements that already apply; the later dates for high-risk AI systems do not postpone those obligations.

For certain providers of AI systems that generate synthetic content and were already placed on the market before 2 August 2026, a transitional deadline

of **2 December 2026** applies to the Article 50(2) marking and detection requirements. New prohibitions introduced by the 2026 amendments also apply from that date.

2 December 2027: the principal requirements for high-risk AI systems classified under Article 6(2) and listed in Annex III apply. These include certain AI systems used for employment and worker management. For an affected application, organisations should establish with the supplier what requirements apply and which responsibilities fall on each party.

2 August 2028: the principal requirements for high-risk AI systems classified under Article 6(1) because they are safety components of, or themselves constitute, products covered by specified Union product-safety legislation in Annex I apply. This may be particularly relevant to some AI-enabled medical devices and other regulated products used in care. The classification of the specific product and AI function should be established rather than inferred simply from its use in a care setting.

Transitional provisions may affect systems already on the market or in use. The applicable position depends on matters including the type of system, when it was placed on the market or put into service and whether it has subsequently been significantly changed. Organisations should therefore establish the relevant compliance pathway and deadline for each system rather than work from a single AI Act compliance date. [3-5]

7.

DATA, EHDS AND CYBERSECURITY: THE INFRASTRUCTURE BEHIND INTELLIGENT CARE

The potential of digital technologies and artificial intelligence depends on something less visible than the technologies themselves: the data and infrastructure on which they operate. The European Health Data Space (EHDS) (Regulation (EU) 2025/327) is becoming an important part of this environment. It establishes a common European framework for the use and exchange of electronic health data for healthcare, the secure reuse of health data for purposes such as research and innovation, and requirements for electronic health record systems. For older persons and long-term care, the EHDS reinforces the need to consider how information is collected, governed and exchanged across health and care settings.

Poor-quality, fragmented or inaccessible data limit the value of even sophisticated digital solutions. When professionals repeatedly enter the same information into different systems, when relevant data do not follow an older person between services or when new technologies cannot connect with existing platforms, digitalisation may add complexity rather than reduce it.

For this reason, the EAN Working Group identified data as one of the central areas of its work, alongside AI and good practice. The discussion increasingly focused on data quality, availability and exchange, interoperability, and the implications of the EHDS.

7.1 Preparing older persons care for the European Health Data Space

The EHDS turns these questions into part of a wider European transition. Regulation (EU) 2025/327 entered into force on 26 March 2025. It generally applies from 26 March 2027, while many of its most significant operational requirements are phased in from 2029 and 2031. [6]

Implementation will take place in stages. By **26 March 2027**, the European Commission is due to adopt a number of key implementing acts establishing detailed technical and operational rules. [7]

From **26 March 2029**, the relevant primary-use requirements apply to the first group of priority categories of personal electronic health data: patient summaries, electronic prescriptions and electronic dispensations. Most of the framework for secondary use also begins to apply from this date. [6, 7]

From **26 March 2031**, the primary-use requirements extend to further priority categories, including medical imaging studies and related reports, medical test results and related reports, and discharge reports. Further categories also enter the secondary-use framework. [6, 7]

7.2 Cybersecurity is also continuity of care

Greater connectivity also creates greater dependency on digital infrastructure. A cybersecurity incident in older persons care may compromise personal information, but its consequences can extend further. Loss of access to documentation, medication information, communication or monitoring systems can disrupt care itself.

Cybersecurity should therefore be increasingly understood as part of quality, safety and continuity management, not solely as the responsibility of an IT department.

The European Commission's Action Plan on the Cybersecurity of Hospitals and Healthcare Providers, published on 15 January 2025, addresses four areas: prevention; detection; response and recovery; and deterrence. It includes measures intended to strengthen preparedness, threat detection, incident response and cybersecurity capabilities across the health sector. [8]

The Commission's Action Plan on Cybersecurity and Artificial Intelligence, published on 7 July 2026, addresses the changing relationship between AI and cybersecurity. Advanced AI can strengthen threat detection, preparedness and response, but it can also increase the scale and sophistication of cyber threats. The Action Plan therefore considers both the opportunities and risks associated with AI for European cyber resilience. [9]

These Action Plans are policy initiatives and should be distinguished from legislation establishing legal obligations for individual organisations.

NIS2, Directive (EU 2022/2555), provides a separate legal framework. Healthcare is one of the sectors of high criticality covered by the Directive. As a general rule, entities of a type listed in the Directive fall within its scope where they qualify as medium-sized enterprises or exceed the relevant size thresholds, although specified entities may be covered regardless of size. Covered entities are subject to cybersecurity risk-management and incident-reporting requirements. [10]

For older persons and long-term care providers, however, coverage should not be assumed simply because an organisation provides care. NIS2 refers to healthcare providers as defined by EU cross-border healthcare legislation, and the position of an individual organisation depends on the services it provides, its legal status and size, any applicable exceptions or specific designation, and the way the Directive has been implemented nationally. Social-care and older persons-care providers are therefore not automatically all within the same NIS2 category. Organisations should establish their position under the applicable national rules. [10]

Regardless of whether an organisation falls within the formal scope of NIS2, continuity planning remains relevant to older persons care. Organisations need to know which systems are critical, who has access to them and what happens when they become unavailable. Staff need to recognise common cybersecurity risks, and providers need workable backup, recovery and incident-response arrangements, including the ability to continue essential care when digital systems fail.

The same discipline applies to generative AI and other externally provided digital services. Before staff enter resident, employee or organisational information into an AI tool, the organisation needs to understand what information may be entered, where and how the data are processed, what contractual and data-protection arrangements apply, and whether the tool has been approved for that purpose. Staff should have clear guidance on the use of public or consumer AI tools for confidential, personal or sensitive information.

Digital maturity should therefore be measured not only by how much technology an organisation uses, but also by its ability to govern, connect and protect that technology — and to continue providing care when it becomes unavailable.





8.

WORKFORCE AND DIGITAL SKILLS: TECHNOLOGY IS ALSO A PEOPLE STRATEGY

Workforce shortages are one of the strongest arguments for digitalisation in older persons care. Technology can reduce repetitive administrative work, improve access to information, support monitoring and help professionals use scarce time more effectively. The EAN survey confirms that reducing professional workload and staff turnover is among the priorities providers associate with digitalisation.

But technology does not automatically create workforce capacity.

Implementation itself requires time. Professionals need to learn new systems, adapt workflows and sometimes operate old and new processes simultaneously. Poorly integrated technology may add documentation, alerts and interfaces rather than remove work.

The relevant question is therefore not simply how much time a technology is claimed to save, but whether it frees up usable professional capacity in everyday practice.

8.1 Digital competence is becoming professional competence

As technologies become more embedded in care, digital competence can no longer remain the responsibility of a small number of technically confident employees.

Different roles require different capabilities. Care professionals need to use systems safely, understand their limitations and recognise when technological output conflicts with their own observation or professional judgement. Managers need to understand implementation, workflow and workforce consequences. Leaders need sufficient digital and AI literacy to make investment, risk and governance decisions.

The EAN survey identified digital literacy, AI use cases, ethics, data privacy and change management among the areas where respondents wanted further training and support. EAN's Position Paper similarly calls for investment in digital skills and ethical leadership among both care professionals and management. [1]

Digital competence therefore includes the confidence to use technology, but also the confidence to question it.

8.2 Technology should improve the work of care

Professionals should be involved early enough to influence technology selection and implementation rather than being trained only after a procurement decision has been made. They understand where time is lost, where information is missing and where a proposed solution may interfere with everyday care.

This involvement also helps distinguish between theoretical and actual efficiency. If AI reduces documentation time but creates additional verification work, the net benefit may be small. If monitoring technology reduces routine checks but produces excessive false alerts, workload may increase.

The most useful workforce test is therefore simple:

Does this technology make it easier for professionals to provide good care?

When technology frees up time, organisations should also consider where that capacity is reinvested. Providers should identify which activities will benefit and check whether the recovered time can actually be used within staffing patterns and workflows.

The workforce ambition of digitalisation should therefore be the better use of human capacity, not simply less human input.

9.

HUMAN-CENTRED DIGITALISATION: KEEPING THE PERSON AT THE CENTRE

The purpose of digital transformation is not to create digital care. It is to improve care with the support of digital technology.

This distinction is particularly important in older persons care because efficiency is only one dimension of quality. Care also depends on dignity, autonomy, trust, relationships, personal history and the ability of individuals to influence how they live.

EAN's Position Paper places this human-centred approach at the core of its position on new technologies and AI. Technology should support autonomy, well-being and safety while complementing rather than replacing human relationships. [1]

9.1 Human contact is not an inefficiency

Digitalisation can appropriately remove tasks that do not require human interaction. Administrative processing, repetitive documentation or routine information transfer may be automated or simplified.

The same logic should not automatically be applied to human relationships.

Older people may value conversation, reassurance, recognition and continuity even where technology could technically perform part of the interaction. AI companions and conversational technologies may offer useful support,

particularly for reminders, information or cognitive stimulation, but EAN's position is that they should complement rather than replace human contact.

This leads to an important distinction for care organisations:

Decisions about automation should therefore take account of its effects on the availability and quality of human contact.

9.2 Autonomy includes the experience of technology

Human-centred implementation also means considering how technology is experienced by the older person.

A monitoring system may improve safety while also increasing a sense of being observed. A digital interface may increase independence for one person while excluding another. An AI system may personalise recommendations while reducing a complex individual to the information available in its data.

Privacy in older persons care is therefore not only data protection. It is also the experience of having a private life.

Providers should consider whether monitoring is proportionate to the risk being addressed, whether people understand how technology affects them and whether meaningful choice remains possible. The appropriate balance will differ according to individual needs and preferences. Information and decision-making support should be accessible, including for people with cognitive impairment; safeguards must follow applicable law and the person's rights.

Digital inclusion is part of the same principle. Older people should not receive poorer access to care simply because they cannot or do not wish to use a particular digital channel. Human-centred digitalisation must therefore retain alternatives where they are needed.

9.3 A simple human-centred test

The ethical implications of every technology will differ, but the fundamental test does not need to be complicated.

Before implementation, providers should ask whether the technology improves something that matters to the person; whether it supports or unnecessarily restricts autonomy; whether monitoring and data use are proportionate; whether the person can understand its role; whether important human contact is protected; and whether professionals can adapt or override the system when individual circumstances require it.

These questions do not oppose innovation. They define the conditions under which innovation contributes to good care.

The future of older persons care will almost certainly be more digital and increasingly supported by artificial intelligence. The European objective should be to ensure that it remains recognisably human.

10.

FROM PILOT TO SCALE: TURNING INNOVATION INTO PRACTICE

Europe does not lack digital innovation in older persons care. Across the EAN network, providers are already experimenting with digital documentation, remote monitoring, telecare, wearables, robotics, artificial intelligence and administrative automation. The greater challenge is turning these technologies into sustainable everyday practice and demonstrating that they create value for older people, professionals and care organisations.

The Working Group's discussions placed increasing emphasis on implementation. This was not an argument against experimentation. Pilots remain essential in a sector in which technologies interact with complex care processes, vulnerable people, professional judgement and highly diverse organisational environments. Their purpose, however, should be to generate enough evidence to make a decision: to scale, adapt or stop.

10.1 From a promising technology to demonstrated value

The decision framework introduced in Chapter 4 provides the starting point. Implementation adds a further question: does the expected value survive contact with everyday care?

A pilot should therefore have an explicit baseline, intended outcome and criteria for success. It should test not only whether the technology functions technically, but whether it fits into the reality of care: whether professionals can use it, whether residents accept it, whether information reaches the

right person, whether it integrates with existing systems and whether it changes an outcome that matters.

This distinction is particularly important because deployment is relatively easy to measure. The numbers of devices, licences, users, alerts or trained employees tell an organisation whether a technology has been introduced. They do not establish whether care has improved. Table 1 in Chapter 4 provides examples of outcome measures for different care challenges. Before the pilot, select the measures relevant to the intended benefit, record the starting position and agree how and when the results will be reviewed.

10.2 What European practice is already showing

The six examples in the 2025 EAN survey outcomes show how members are addressing different care and organisational needs. For Malina Portal in Slovakia, the respondent reported a 30% reduction in documentation time and fewer medication errors, alongside the importance of involving nurses and adapting to workflows. The survey synthesis does not specify the measurement method, baseline period or sample for the percentage reported. The Italian Teia Care contribution reported fewer falls and reduced professional workload; the French Upmeet example described an AI meeting assistant that reduced administration.

Other examples highlight how benefits and implementation conditions differ. The German Navel Social Robot contribution reported greater engagement among residents but limited effects on staff workload. Care Connector in Scotland was described as a pilot combining AI and telecare, with governance among the barriers. Perpetuo Socorro Residence in Spain described several digital systems and stressed that training should precede deployment. Appendix A provides the complete six-case overview from Marcel Smeets's September 2025 survey synthesis, including the lessons contributed by respondents.

The examples reveal common implementation lessons. Technologies create more value when they address an identifiable problem, fit existing care processes and involve professionals early. Conversely, a technically sophisticated solution may generate little value if it creates duplicate documentation, excessive alerts, additional interfaces or processes that staff cannot realistically incorporate into everyday work.

Integration may therefore matter as much as technological novelty. As providers adopt more digital systems, every stand-alone application potentially adds another interface, login, data transfer, training requirement and vendor dependency. The relevant question is increasingly not only what a technology can do, but how well it works within the organisation's wider care and information environment.

10.3 Designing implementation for learning and scale

Two European approaches illustrate how organisations can reduce the gap between innovation and implementation.

The first is the Test Before Invest model. Rather than making a full procurement decision on the basis of a demonstration or technical specification, providers can test a solution in a real care environment and evaluate its fit with residents, professionals, workflows and existing infrastructure. The published EDIH Northeast Bohemia case describes Anume Care pad trials in Jindřichovice pod Smrkem and Rokytnice nad Jizerou, followed by acquisition of 20 pads by the Liberec Region. The report describes staff participation, positive feedback and fewer routine room checks. This experience illustrates how testing in a care setting can inform an investment decision. [11]

The French Comète IA Care initiative provides a more detailed example of planning for evaluation and potential scaling. Julien Brunet, administrator of GCSMS Comète Bretagne, describes the project in a published account of its aims for management and care. [12]

The project proposal contributed to the Working Group describes a planned process beginning with the needs of users, professionals and managers, followed by prioritisation of AI use cases according to feasibility and expected impact. It envisages proof of concept, field testing, iteration, staff training, pilot deployment and evaluation, followed by consolidation and assessment of transferability before wider deployment. The proposal sets out these stages as the planned pathway for development and evaluation.

Particularly relevant is the breadth of the proposed evaluation. The proposal includes service quality and organisational efficiency alongside quality of working life, participation, acceptability of AI, ethical considerations and the boundary between AI recommendations and human intervention. The proposal defines target indicators for subsequent evaluation. The proposed evaluation treats the technology as part of a care organisation.

This is a useful design for older persons care because it sets out a pilot as a structured learning process. The question is no longer simply *"Did the technology work?"* but *"Did it create sufficient value, under acceptable conditions, to justify wider implementation?"*

10.4 From individual projects to a European learning model

The challenge for Europe is therefore not simply to generate more examples of innovation. It is to become better at distinguishing promising solutions from those that are ready for wider implementation.

One possible contribution through the EAN network is to share practice in a way that makes the level of evidence visible. A useful distinction is between a promising solution, one that addresses a relevant care problem; a tested solution, used in a real care environment; a measured solution, where predefined outcomes have been evaluated; and a replicated solution, where benefits and implementation conditions have been demonstrated across more than one setting. Replication strengthens the case for scaling but does not guarantee transferability to every organisation.

This would help providers judge how far an experience can inform their own decisions and what further testing may be useful. It would also make unsuccessful experiences valuable. Understanding why a technology did not integrate, was rejected by users, created excessive workload or failed to improve the intended outcome may be as useful to another provider as a success story.

The same principle should apply to scaling. A successful pilot does not automatically justify organisation-wide deployment. Scaling changes the environment: more professionals require training, infrastructure differs between sites, workflows vary and governance, supplier support and costs become more significant. The decision to scale should therefore be treated as a second management decision, supported by evidence from the pilot rather than as its automatic conclusion.

Such exchange could extend from sharing technologies to sharing implementation knowledge: what problem was addressed, why a particular solution was selected, what conditions were required, how professionals and older people experienced it, what outcomes changed, what did not work, and why the organisation ultimately decided to scale, adapt or stop.

This is the transition from isolated innovation towards a learning European older persons care sector. The future of digital care will depend less on how many technologies Europe pilots than on how effectively it identifies, evaluates, integrates and scales those that demonstrably improve care.

11.

THE WORK OF THE EAN WORKING GROUP DIGITALISATION 2024–2026

This report is the result of continuing work within the EAN Working Group Digitalisation. It builds on the 2024 report, which identified differences in digital maturity and the need for vision, investment and skills. [2] Subsequent discussions increasingly focused on the practical choices providers face as AI and connected information systems enter care.

The Working Group's contribution has been to bring together provider experience, discussion with experts and European policy developments. This exchange has shaped practical recommendations grounded in the priorities and implementation experience of care organisations.

11.1 From digitalisation to implementation

During 2024 and 2025, the Working Group organised its discussions around data, artificial intelligence and practice examples. Data availability and exchange shaped the scope for more advanced services; AI raised questions of reliability and responsibility; and provider experience helped test what these developments meant in everyday care.

An early ambition was to develop a decision tree to help providers navigate AI and digital technologies. Existing initiatives, including DigiCare4CE, were considered as possible sources of inspiration. The emphasis subsequently moved towards a wider implementation approach: why a technology should

be used, which problem it should address, and when an organisation should start, scale or stop.

The practical framework in Chapter 4 is the report's synthesis of that work. It combines technology selection with integration, evidence and organisational readiness, rather than presenting a catalogue of preferred products.

11.2 Learning from members and European practice

The 2025 member survey provided a practical reality check. Participating organisations described different levels of maturity alongside recurring expectations about quality, safety, autonomy and professional workload. Their experiences helped connect the Working Group's discussion with the conditions in which technologies would have to operate.

Cases contributed by members added practical insight into implementation, including user satisfaction, time savings and changes in care. Describing how these outcomes were assessed helps other providers interpret the experience and consider its relevance to their own organisations.

At the General Assembly in Lisbon on 7 October 2025, the Working Group's next steps included a new statement on digitalisation and AI, a December webinar and preparation of its report. These plans are recorded in the published General Assembly minutes. [13]

11.3 A human-centred European approach

EAN's Position Paper is dated 30 October 2025. It places dignity, autonomy, privacy, trust and human relationships at the centre of the use of technology and AI. [1] This provided the values against which the practical recommendations in this report should be judged.

11.4 Report 2.1 takes shape

At the Working Group webinar of 4 December 2025, the emerging outline and messages of Report 2.0 were presented and discussed. The material described a transition from digitalisation towards AI-supported care models and brought together six messages:

- **Europe needs a clear digital care vision.**
- **Implementation first – not more pilots.**
- **Interoperability must be the rule.**
- **Digitalisation should be treated as investment, not merely cost.**
- **European values – ethics, autonomy and privacy – must be protected.**
- **Upskilling and reskilling are the backbone of transformation.**

These messages shaped the present report. The call for implementation first concerned what follows a pilot: evidence should support a decision and sustained use where justified. The emphasis on investment connected expenditure on technology, integration and skills with its contribution to care quality and organisational capacity.

11.5 What the Working Group learned

Across the Working Group's discussions, member research and practice examples, a consistent lesson emerged: digital transformation requires organisational transformation. The starting point is a care need and an expected benefit. Data quality, integration, professional competence and staff involvement then determine whether a technology can become useful everyday practice.

The same learning applies to AI. A technically capable system needs a care process in which its output can be understood, questioned and acted upon. Professional responsibility, older people's choices and the quality of human relationships remain central to that process.

A useful basis for further exchange is implementation experience: the conditions required, the changes observed, the difficulties encountered and the reasons for continuing, adapting or stopping. The decision framework and evaluation approach in Chapters 4 and 10 turn these lessons into practical tools.

The next question is therefore:

What should Europe, older persons care providers and their associations do next?

The following EAN Vision 2030 and Strategic Priorities translate the Working Group's learning into a proposed direction that can be adapted to different national and organisational contexts.




AI PSYCHOLOGIST
Resolve all your problems

12.

EAN VISION 2030 AND STRATEGIC PRIORITIES

The vision for 2030 — Digital Care That Remains Human Care

The proposed vision is for older people to experience more personalised, preventive and connected care, supported by technology and AI while preserving autonomy and meaningful human relationships. AI opens possibilities for new models of care, including support between visits and earlier recognition of changing needs. Their value depends on how they improve the person's experience of care.

This ambition builds on EAN's human-centred Position Paper and the priorities expressed by members. [1] The four priorities below offer a direction for discussion and action. They do not constitute an agreed EAN work programme or commitments by member associations. The choice, pace and organisation of implementation will vary between countries and providers, reflecting care systems, funding, infrastructure, workforce capacity and national requirements.

12.1 Make useful technologies part of everyday care

The priority is to make sustained use easier when a technology has demonstrated value in the relevant care setting. Experience from other organisations is useful when it explains the conditions for implementation: how work changed, what support was needed and what difficulties remained.

Sharing such experience across the EAN network could help organisations assess what is transferable to their own services. Practice collections or exchanges are possible forms of cooperation, to be considered according to members' interests and capacity.

Digitalisation needs to be considered an investment in care and organisational capability. Funding decisions should take account of integration, staff development, maintenance and continued use, alongside the initial purchase. The appropriate funding route and case for investment will depend on the national and organisational context.

12.2 Connect information across care settings

The ambition is for relevant information to follow the older person between services, with appropriate privacy and security. Better continuity matters across home care, residential care, primary care, hospital and rehabilitation, especially where health and social care responsibilities meet.

Progress depends on interoperable systems, workable data exchange and procurement decisions that support continuity. The practical route will differ according to national infrastructures and the systems already in use.

Common concerns about data portability and integration could inform dialogue with suppliers and public authorities. European exchange may help identify shared needs while leaving room for different national approaches.

12.3 Strengthen workforce skills and capacity

The workforce priority is to enable professionals and managers to use digital tools with confidence and critical judgement, with time and support to learn as their work changes. Upskilling and reskilling need to reflect actual responsibilities, from everyday documentation to decisions about introducing AI.

Practical options include learning within the workplace, support from colleagues and cooperation with education providers. Their organisation will depend on local staffing, professional education and available resources.

The intended benefit extends beyond technical competence: more manageable work and greater capacity for direct care, coordination and individual attention. Staff experience should help determine whether technology is achieving that benefit and how work needs to change.

12.4 Ensure AI-supported care strengthens choice and human contact

The priority for older people is to benefit from new forms of support while retaining an understandable and meaningful say in their care. More personalised monitoring or support between visits should respond to individual needs and preferences, with access to human help when it is needed.

This means involving older people and, where appropriate, families in shaping how services use AI. Accessible explanations, proportionate monitoring and opportunities to question decisions are part of the care experience. Arrangements need to reflect the person's circumstances and applicable rights.

The ambition is care that combines earlier support and greater autonomy with continuity of human relationships. Different countries and organisations may pursue this through different service models; dignity, privacy and human responsibility remain the common principles.

Together, these priorities describe the direction of progress. Exchange within EAN offers a possible way to learn across different settings, while decisions about activities, responsibilities, resources and timing remain with the organisations concerned.

13.

CONCLUSION: MAKING DIGITALISATION WORK FOR CARE AND CARERS

The work of the EAN Working Group shows that better technology decisions require clear purpose, evidence and organisational responsibility. Progress should be judged by what changes for older people and professionals, including effects on autonomy, safety, workload and the experience of care.

The practical task is to connect technology with the care process: involve the people affected, establish the necessary data and integration, evaluate outcomes and retain the ability to adapt or stop. EAN's human-centred position provides the guiding principle: digitalisation should strengthen dignity and professional care while protecting human relationships. [1]

The objective is better care, enabled by technology where it adds value.

A Practical EAN Check: 10 Questions Before Implementing AI or Digital Technology

The following questions translate the central lessons of this report into a practical check that providers can use before committing to a new digital solution or AI application.

1. What problem are we trying to solve?
Can we describe the care, workforce or organisational problem without referring to a particular technology?

2. What should become better?
What measurable benefit do we expect for older people, professionals or the organisation?

3. Is technology – and specifically AI – the right solution?
Could the same outcome be achieved more simply, safely or effectively in another way?

4. Who will be affected and have they been involved?
Have professionals, older people and families been involved in the areas where their experience or behaviour will determine whether the solution succeeds?

5. What data does the solution need and create?
Do we understand where the data come from, where they go, who can access them and how they can be exchanged or retrieved?

6. What evidence supports the expected benefit?
Is the evidence based on a demonstration, a pilot, provider experience, measured outcomes or independent evaluation – and is it relevant to our care setting?

7. What can go wrong?
What are the consequences of incorrect information, missed events, false alerts, system failure, inappropriate use or cybersecurity incidents?

8. Where must human judgement remain?
Can professionals understand, question and override the system, and is responsibility for decisions clear?

9. How will we know whether implementation has succeeded?
Have we defined the baseline, outcomes and indicators before implementation begins?

10. What would make us stop?

Have we agreed when insufficient value, unacceptable risk, poor acceptance, lack of integration or excessive cost would justify adapting or discontinuing the solution?

These questions are deliberately technology-neutral. Specific technologies will change rapidly. The discipline required to evaluate them should remain.

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APPENDIX A — PRACTICE EXAMPLES FROM THE 2025 EAN SURVEY

Source: EAN WG DIGIT survey outcomes, compiled by Marcel Smeets and circulated on 15 September 2025. The following six cases reproduce the substance of members' contributions in an edited overview. Outcomes are attributed to the contributing respondents. This is the survey used for Report 2.0.

Example and country	Application	Member-reported experience	Implementation lesson
Malina Portal | Slovakia	Digital nursing documentation	The respondent reported a 30% reduction in documentation time and fewer medication errors.	Start small, involve nurses and adapt the solution to existing workflows.
Teia Care | Italy	AI-based health monitoring	The respondent reported fewer falls and reduced professional workload.	Accessibility for older people is an important condition for use.
Upmeet | France	AI meeting assistant	The respondent reported reduced administrative burden and improved efficiency.	Simplicity helps staff adopt the solution.
Navel Social Robot | Germany	Social interaction	The respondent reported greater resident engagement, with limited effects on staff workload.	Set expectations according to the intended benefit for residents.
Care Connector | Scotland, UK	AI and telecare	The contribution described a pilot; governance was among the barriers encountered.	Include governance arrangements in pilot planning.
Perpetuo Socorro Residence | Spain	Wearables, medication management, SILAND administrative automation, dementia stimulation and microchips	The contribution described the use of multiple systems and emphasised preparation for deployment.	Provide training before introducing the systems.

For the Malina Portal percentage, the synthesis does not specify the measurement method, baseline period or sample. Anume and Comète are discussed separately in Chapter 10; they are not among the six cases in this survey outcomes document.

APPENDIX B — ASSISTIVE TECHNOLOGIES FOR SAFETY AND MONITORING IN OLDER PERSONS CARE

Original overview prepared by Marek Šoltys, 25 February 2026. Adapted into English for this report. The overview focuses on falls management and also covers mobility, activity and vital-sign monitoring, help requests and staff response. Product functions reflect the overview compiled in February 2026. The table is a practical map of functions across the care pathway. Device selection requires assessment of the person, setting, workflow and specific product configuration. Supplier descriptions explain intended functions; measured care outcomes require evaluation in use.

B.1 Technology categories and their role in care

Category	Technology	Role in care	Implementation considerations
Alarms and exit systems	Bed or chair sensors, pressure pads and exit alerts.	Alert staff when a person gets up and may need assistance.	False alarms; whether the alert reaches someone able to respond; individual rather than blanket use.
Wearable sensors	Wristbands, clips, motion sensors and instrumented garments.	Monitor mobility, gait and balance; support risk assessment or fall detection, depending on the device.	Willingness and ability to wear the device; charging; loss; suitability for people living with dementia.
Contactless environmental sensors	Radar and infrared sensors installed in rooms or circulation areas.	Monitor movement and changes in activity; detect specified risk events without a worn device.	Coverage, blind spots, calibration, false alarms and integration with staff alert systems.
Camera and AI systems	Video or spatial sensing with analysis of movement and events.	Detect falls or exit events and provide information for incident review.	Privacy, acceptance, camera placement, masking, access and retention of images or other data.
Response and alert infrastructure	Nurse-call platforms, telecare hubs, staff devices and escalation systems.	Route an alert, identify who should respond and record follow-up.	Response responsibilities, coverage, escalation and compatibility with the detection system.

The same product can contribute to more than one stage: assessing risk, monitoring change, supporting prevention, detecting an event, routing a response or reviewing an incident. In particular, an exit alert or fall detector needs a defined staff response.

B.2 ALARMS AND EXIT SYSTEMS

Solution or supplier	Technology described	Function and place in the care pathway
Securitas Healthcare Arial + M210	Bed/chair pads and nurse-call integration	Exit alerts, staff notification and central reporting; also part of the response infrastructure.
Anume Care monitoring	Pads and central monitoring; CYGNUS connection described in the source	Bed-exit monitoring, time out of bed and configurable exit alerts.
Curbell Medical BC300 / BC600	Pressure pads, monitors, floor mats and motion sensors	Bed/chair exit alerts linked to nurse-call systems; also contributes to routing a response.
TIDI Products Posey Falls Prevention	Wired or wireless alarms and bed/chair/toilet sensors	Exit alerts and connection to nurse-call infrastructure.
Tunstall Carecom	Wireless nurse-call and care-assistance system	Help requests, location information and care alerts within residential care.
Hillrom Centrella Smart+	Smart-bed exit alarms and integration	Bed-exit alerts and bed-state information in settings using compatible smart beds.
Alerta / AlertaMats	Floor, bed and chair mats and alarm products	Movement or exit alerts; nurse-call connections depend on the configuration.

B.3 WEARABLE SENSORS

Solution or supplier	Technology described	Function and place in the care pathway
Tunstall Vibby Fall Detector	Wearable motion-based detector with telecare connection	Automatic fall alerts and manual help requests; requires regular wearing and a response connection.
Philips Lifeline AutoAlert	Wearable medical-alert pendant	Fall alerts and access to assistance. The source notes that not every fall is detected.
BioSensics LEGSys	Wearable motion sensors and analysis software	Gait, dynamic balance and fall-risk assessment; an assessment role rather than an immediate response alarm.
BioSensics BalanSens	Wearable balance-assessment platform	Assessment of balance and fall risk in rehabilitation and related settings.
BioSensics PAMSys	Wearable activity and posture monitoring	Monitoring postures, transitions and walking during daily activities; changes over time can inform review.

B.4 CONTACTLESS AND CAMERA-BASED MONITORING

Solution or supplier	Technology described	Function and place in the care pathway
Vayyar Care	Imaging radar	Contactless fall detection in rooms or home-care settings.
Xandar Kardian XK300 / XK-FD	Ultra-wideband radar	The source distinguishes movement, presence and vital-sign monitoring from the fall-detection application.
Milesight VS373	Millimetre-wave radar	Fall and unusual-movement detection; integration with the care workflow remains a selection consideration.
Hikvision Radar Sensor-based Care	Radar sensing	Contactless fall detection within the relevant monitoring infrastructure.
Sensio RoomMate	Contactless room sensor and analysis	Falls, exits and room-activity alerts with anonymised monitoring; no worn device is required.
VirtuSense VSTAlert	Machine vision and spatial analysis	Alerts concerning anticipated bed/chair exit, with routing and escalation to staff.
Careium Night Owl	Infrared camera and analysis	Night-time monitoring and identification of risk events; requires a clear policy for image-based monitoring.
Alerta infrared beam alarms	Infrared movement sensing	Basic movement or exit alerts, with less contextual information about the event.

B.5 FURTHER CAMERA SYSTEMS AND RESPONSE INFRASTRUCTURE

Solution or supplier	Technology described	Function and place in the care pathway
Konica Minolta MOBOTIX Nurse Assist	Camera and video analytics	Fall or unusual-movement detection and staff alerts; privacy settings and acceptance are central.
Hikvision AI Fall Detection	Camera and video analytics	Automatic fall alerts in monitored areas without a wearable device.
KamiCare / Kami Vision	Vision-based analysis	Fall detection and activity monitoring in senior-care settings; deployment and privacy arrangements require review.
Canon AI-powered Fall Detection System	Video analytics with additional sensing described in the source	Fall detection, behaviour analysis and alerts; assess the specific configuration and data captured.
Ascom nurse call + Myco	Nurse-call infrastructure and staff smartphone	Receiving, routing and managing alerts and staff responses; a workflow role rather than a stand-alone fall sensor.
TeleAlarm NurseCall and home emergency-call portfolio	Nurse-call and emergency-call infrastructure	Sending help requests or incident alerts to staff or a monitoring centre.

Systems already listed in B.2–B.4 can also support post-fall response: the original overview additionally identifies Lifeline AutoAlert, Tunstall Vibby with a telecare hub, Securitas Arial and Curbell nurse-call integration in this role. They are consolidated here to avoid repeating product entries.

APPENDIX C — EAN WORKING GROUP DIGITALISATION: MEMBERS AND WORKING METHOD

The EAN Working Group Digitalisation continued the work that led to the first EAN digitalisation report in February 2024. Its purpose was to support and guide EAN members in addressing digitalisation and ICT issues and to provide input for EAN discussions and positioning. For the next phase, the group focused more closely on data, artificial intelligence and practical examples of digital solutions in older persons and long-term care.

C.1 Participants

The working group was composed of representatives of care providers, sector organisations and technology-related organisations from several European countries, along with EAN support. Participants recorded across the meetings included:

- Věra Husáková, Clementas (Czech Republic);
- Clémence Lacour, FNAQPA (France);
- Jessica Grausgruber, SeneCura (Austria);
- Ulrika Olsson, Arjo (Sweden);
- Cornelia Sicher-Planinschetz, Myneva (Austria);
- Pascale Hulpiau, Stad Gent (Belgium);
- Michiel Kooijman, ActiZ (the Netherlands);
- Michael Ganter, Paul Hartmann (Germany); and
- Marcel Smeets, EAN EU Executive Consultant (Belgium).

Participation varied between meetings. External experts and project representatives were also invited to contribute to specific discussions.

C.2 Working method

The group worked through a combination of in-person and digital meetings, presentations, round-table exchanges and follow-up tasks between meetings. The first meeting of this phase took place in Prague on 5–6 December 2024, with subsequent digital meetings and exchanges linked to EAN meetings. Discussions combined members' practical experience with input from external initiatives and experts, including presentations on DigiCare4CE and vocational education and training, and consideration of other decision-support approaches.

The work was iterative. Members first explored the state of play in data, AI and good practice, including data quality and exchange, the relationship between health and social care, change management, workforce implications and the conditions for successful innovation. The group then examined how these issues could be translated into practical guidance for older persons care providers. An early proposal for an AI decision tree evolved through discussion into a broader question: what problem should technology solve, and how should an organisation decide when to start, implement, integrate, scale or stop its use?

Meetings were used to test ideas rather than simply endorse technologies. Members compared optimisation of existing work with more fundamental transformation of care, considered the added value of AI for quality and workforce pressures, and discussed trust, assessment, interoperability and implementation. They were also asked to review existing initiatives, contribute examples and good practices, revisit the findings of the first EAN digitalisation report and help develop a shared direction for subsequent EAN discussions.

This process informed the practical orientation of the present report: starting with the care problem, learning from implementation experience and assessing technology in relation to its effects on older people, professionals, organisations and the wider care system.

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