

EVALUATING WORKING CONDITIONS IN RESIDENTIAL CARE: A PARTICIPATORY APPROACH FROM POLAND

Introduction

Residential care is a high-risk occupational safety and health (OSH) environment due to its 24/7 service delivery, physically demanding resident-handling tasks and significant psychosocial demands. As a result, the sector faces multiple OSH-related challenges, including musculoskeletal disorders (MSDs), work organisation issues and limited access to training and equipment. In Poland, persistent resource constraints and relatively low staffing capacity, compounded by population ageing and the growing demand for formal care, translate into chronic risk drivers such as staff shortages, high workloads, an ageing workforce and a lack of ergonomic equipment, all of which increase OSH risks and undermine workforce sustainability.

Against this backdrop, Leon Szuman Nursing Home in Toruń (Polish: Dom Pomocy Społecznej, DPS Toruń)¹ represents a pertinent example of good practice at facility level. The institution is a residential long-term care (LTC) facility for older people and people with chronic somatic illnesses, with capacity for 174 residents (75 for older people and 99 for people with chronic somatic illnesses). It is run by the Municipality of the City of Toruń (northwest of Warsaw) and operates as a complex of three connected buildings, which reflects the differentiated organisation of care services within the facility.

In response to both sector-wide constraints and local operational realities, including growing care needs and chronic staff shortages, DPS Toruń introduced a continuous, standardised approach to evaluating and monitoring care standards and working conditions following the establishment of an inter-company trade union organisation. The central rationale was continuous oversight to identify the most acute risks, including high workloads, staffing gaps, training needs and deficiencies in assistive equipment such as lifting devices, and to direct the limited resources to the most critical areas. Importantly, the approach was designed as participatory – implemented by management in cooperation with employees and the trade union – to ensure that OSH priorities and care-quality needs were assessed and addressed through an ongoing improvement cycle rather than one-off audits.

Crucially, the evaluation system is not described as a single formalised document or checklist; rather, it is an embedded organisational practice based on regular dialogue between management and staff. Its core mechanism consists of regular small-group meetings between management and different staff groups, designed to identify problems, evaluate compliance with internal procedures and statutory staffing requirements, and trigger corrective actions. This is complemented by an open-door communication culture and ongoing workplace monitoring, including through social labour inspectors linked to the trade union.

This case study documents DPS Toruń's approach as an example of good OSH practice in residential care. It focuses on how the introduction of evaluation standards can serve as a practical governance tool for risk identification, prioritisation, worker participation and social dialogue at facility level. The case study is part of a broader research project aimed at providing an overview of research on OSH in residential care work,² and is based on desk research, including publicly available institutional information, and qualitative evidence from interviews with representatives of the DPS Toruń care facility.

¹ More information is available at: <https://torun.naszdzps.pl/>

² The full report — *Residential care workers: a comprehensive overview of occupational safety and health* — is available at <https://osha.europa.eu/en/publications/residential-care-workers-comprehensive-overview-occupational-safety-and-health>

Description of the intervention

Background information and objectives

While the local context of DPS Toruń reflects the broader structural pressures facing Polish residential care, evidence from the interviews highlighted several facility-specific OSH challenges that shape day-to-day exposure to risk.

First, staffing constraints remain a persistent vulnerability, particularly with regard to nurses, due to the sector's limited financial attractiveness and the pay gap between nursing in hospitals and nursing in social care settings. These pressures intersect with an ageing workforce, with most staff reported to be approaching retirement age, which raises concerns about continuity of staffing and the cumulative ergonomic burden of physically demanding care work. Second, the facility's physical environment creates additional ergonomic risks. Some of the infrastructure was designed decades ago for more mobile residents, but the resident profile has since shifted towards greater dependency and a higher proportion of bedridden individuals. This resulted in narrow rooms that were not originally designed to accommodate lifting devices. Although smaller lifting solutions have since become available, manual handling remains a key OSH risk and a recurring focus of improvement efforts. Third, the interviews highlighted important organisational and competence-related burdens. Recruitment pathways, including those supported by the local employment office, bring in candidates who may lack experience with older people, which creates substantial onboarding demands for existing staff and underscores the need for systematic training. In addition to OSH training, staff development needs include psychological and practical preparation for caring for residents with complex needs and managing challenging interactions. The facility explicitly aligns its training priorities with the need to manage verbal and physical aggression and other psychosocial stressors typical of residential care. Finally, the Covid-19 pandemic exposed acute OSH vulnerabilities, particularly in relation to access to personal protective equipment (PPE), which staff representatives raised as a critical precondition for both worker safety and continuity of care.

To address these challenges, the management team at DPS Toruń introduced a continuous, standardised system for evaluating care standards and working conditions. This was developed following the establishment of an inter-company trade union at the facility in 2020, which prompted the adoption of a more systematic – and explicitly participatory – approach to evaluating care standards and working conditions. First, the emergence of the union exposed dissatisfaction with working conditions, including inadequate staffing levels and insufficient assistive equipment, especially resident lifting devices, presented as necessary to protect workers' health and sustain safe care delivery. The evaluation system that was subsequently developed should therefore be understood less as a one-off audit instrument and more as an embedded governance practice based on structured dialogue between management, employees and union representatives. It relies on regular (quarterly) team-based meetings and an open-door communication model to identify problems and key pressure points, such as staffing, training, equipment and work organisation, and to trigger corrective action.

Key objectives of the intervention included:

- Risk anticipation and prioritisation: establish ongoing oversight of working conditions and care delivery, detect psychosocial and physical risk drivers early and prioritise corrective actions.
- Targeted allocation of scarce resources: use evaluation outputs to justify and steer investments in ergonomic equipment, such as lifting devices, training and other improvements in areas where risk and workload are highest.
- Workforce professionalisation and retention support: strengthen recruitment and onboarding pathways, including cooperation with the local employment office, and provide comprehensive training packages, covering OSH and caring for residents with complex needs, to stabilise the workforce in the context of staff shortages.
- Social dialogue and advocacy for systemic change: work closely with trade unions to pursue external funding and policy reforms, including staffing-related demands, which are necessary to sustainably improve working conditions and care standards beyond the facility's own financial capacity.

What has been done and how

In practice, the intervention has evolved into a continuous improvement cycle that combines routine monitoring with follow-up actions. Importantly, the evaluation system that emerged from the cycle is not primarily a formalised tool (e.g. a single checklist or table); rather, it operates as an embedded governance practice based on structured communication, the participatory identification of problems and recurring feedback loops to link identified needs with corrective measures.

Continuous monitoring of care standards and working conditions (internal governance tool)

The core monitoring mechanism is a cycle of regular, structured meetings between the facility's director and different staff groups, designed to generate systematic feedback on working conditions and service delivery. These meetings are organised separately for different organisational units, including therapeutic care teams and administrative, technical and financial support staff, and are held quarterly, with each session lasting at least two hours. The format is deliberately designed to allow employees to raise concerns directly, without the inhibiting presence of their immediate line managers. After the staff meetings, the director holds follow-up discussions with unit managers to translate emerging issues into operational decisions and coordinate implementation.

In addition, the facility maintains an open-door communication model, whereby employees may raise OSH-related issues outside the formal meeting cycle. The monitoring agenda is not limited to ad hoc complaints, but also involves reviewing compliance with internal procedures and statutory requirements, including staffing indicators, and reflects a broader shift towards continuous organisational learning. Finally, staff-side monitoring capacity is strengthened through social labour inspection³ operating within the trade union, which reportedly involves inspectors observing conditions 'on an ongoing basis', reporting hazards and technical deficiencies, and supporting the timely remediation of shortcomings. This arrangement was presented as contributing to sustained OSH oversight and to the absence of reported workplace accidents.

Workforce recruitment pipeline linked to structured training and competence development

To mitigate staff shortages, DPS Toruń cooperates with the local employment office, which it uses not only to post vacancies, but also to support a structured pathway for recruitment and retention. Recruitment is linked to project-based, temporary placements, such as annual programmes, and involves the facility interviewing candidates and selecting those to be offered these placements. A significant enabling factor is the reported use of subsidised employment, with a substantial share of wage costs covered by the employment office. This has been described as financially critical for municipal providers. The pathway also includes internships in areas such as occupational therapy, with successful placements leading to employment in some cases.

Training is considered essential to complement recruitment, particularly because new entrants may lack experience in residential care for older people. This is often delivered internally by DPS Toruń staff, with some modules financed through external projects. Training priorities explicitly include OSH, psychological skills for managing challenging interactions, including verbal and physical aggression, and practical skills for caring for residents with complex needs.

Participatory implementation through social dialogue and external resource mobilisation

A distinctive feature of the DPS Toruń case is that implementation is embedded in institutionalised social dialogue between management, employees and the trade union. Evidence from interviews pointed to the establishment of the union as a catalyst for the subsequent development of the evaluation practice and a more systematic identification of OSH-related deficiencies, especially shortages of assistive equipment such as lifts and shortcomings in workplace facilities and PPE during the pandemic. This participatory approach is not limited to internal deliberation but also supports external advocacy and resource mobilisation⁴ at municipal and national levels, with the aim of securing funding and systemic adjustments, including those related to staffing. For example, DPS Toruń took part in an EU-funded project from 2024 to 2026 titled 'Healthy and active' (Polish: 'Zdrowi i aktywni') (Gmina Miasta Toruń, 2024), which provided equipment, including office chairs and footrests, to improve workplace

³ 'Social labour inspection (SIP) is an important element of the labour protection system operating in Poland. It is a social service performed by employees, aimed at ensuring OSH in the workplace and protecting employee rights in this area' (source: <https://www.pip.gov.pl/o-nas/wspolpraca/spoleczna-inspekcja-pracy>)

⁴ More information is available at: <https://torun.naszdps.pl/projekty-unijne>

ergonomics for administrative staff. Care staff received preventive health checks and rehabilitation treatments, as well as training on occupational burnout. The project also included staff training from an external company on the correct procedure for transferring residents to wheelchairs.

With regard to advocacy actions, examples include joint efforts by management and the trade union at national level to improve conditions in the care sector through participation in roundtables, such as a session held on 19 November 2024 organised by Warsaw-based NGO COZZ with ministry representatives and employers in the care sector, and meetings organised by the Ministry of Family, Labour and Social Policy to discuss issues facing care homes, which were attended by management representatives.

Crucially, the model links dialogue to concrete OSH-related improvements. The most significant examples include incremental investments to reduce manual-handling risks, especially through lifting devices; improved availability of PPE during the Covid-19 pandemic; and enhancements to 'everyday ergonomics' and welfare infrastructure, including reorganising staff rooms to separate eating and changing areas, providing personal lockers for staff, and introducing a structured system for issuing work clothing and footwear, including a protocol allowing the OSH specialist to authorise their premature replacement where necessary. The interviews indicated that OSH measures extend beyond bedside care to encompass the ergonomic needs of administrative staff, including the provision of chairs, footrests and computer peripherals, consistent with a more comprehensive approach to OSH across occupational groups within the facility.

Finally, the facility's OSH culture is reinforced through routine OSH training beyond core staff, including volunteers and interns, such as a dedicated training cycle organised in October 2025,⁵ thereby demonstrating that safety procedures are treated as regular organisational standards rather than one-off interventions.

Results

Overall, the institutionalisation of continuous evaluation standards at DPS Toruń has produced practice-oriented outputs and intermediate organisational effects. It has strengthened the facility's capacity to systematically identify OSH- and care-related pressure points, to translate them into prioritised remedial actions and, most crucially, to mobilise resources and cooperation, including with worker representatives, to support concrete improvements.

1. Tangible improvements in ergonomic working conditions

A key result reported by the interviewees is the gradual upgrading of ergonomic safeguards in everyday care work, most notably through the acquisition of resident-lifting devices. Importantly, interviewees mentioned that implementation required practical adaptation to the built environment. For example, smaller lifting devices were introduced into narrow resident rooms in older parts of the facility to facilitate assistive transfers in these confined spaces. However, the improvements extended beyond patient handling. Staff welfare facilities were reportedly upgraded through the provision and replacement of lockers and the separation of changing areas from eating and rest areas, thereby addressing the privacy and recovery needs of staff during shifts. The interviews also indicated that ergonomic improvements have increasingly addressed non-care occupational groups such as office staff, who have been provided with chairs, footrests and computer peripherals, thus reflecting a broader approach to OSH beyond 'bedside' work.

2. Increased training provision and professionalisation of care work

The interviews highlighted that the evaluation-driven identification of problems has been linked to more targeted competence development, including explicit OSH training. Beyond general OSH content, the interviewees highlighted training focused on improving the safe performance of routine but physically demanding tasks, such as transferring residents to wheelchairs. This underscores the importance of professionally supervised practice, even for daily tasks, to ensure that established routines are aligned with safe techniques. This emphasis on competence development is reinforced by cooperation with the employment office, where upskilling is discussed as part of the broader recruitment model and as a mechanism to stabilise staff in a high-turnover environment.

⁵ More information is available at: <https://torun.naszdps.pl/n%2Cszkolimy-wolontariuszy-i-praktykantow>

3. Strengthened recruitment/entry pathways amid labour shortages

While labour shortages remain a structural constraint, the DPS Toruń approach has supported more systematic recruitment and onboarding via cooperation with the local employment office, combined with a training package designed to bring entrants up to the required competence levels for residential care work. As documented in earlier projects, this type of approach can generate measurable employment outcomes, thus highlighting the potential of training pipelines as a partial mitigation tool. The staffing situation recently became ‘more stable’ after a period characterised by retirements and subsequent recruitment, even though onboarding new entrants, many of whom lack experience with older people, requires significant internal training efforts and a time commitment from existing staff. Vacancies are currently filled and statutory staffing indicators achieved through the directorate’s active approach and cooperation with the employment office.

4. Reinforced social dialogue and external advocacy capacity

A notable result has been the consolidation of cooperative social dialogue, described as relatively rare in the sector, with trade unions actively articulating demands, especially regarding staffing indicators, and jointly pursuing solutions through external funding and policy channels. The interviewees attributed system-level effects to these joint efforts, including involvement – together with national-level unions – in legal changes related to statutory staffing ratios (i.e. the number of patients per caregiver).

5. Broader occupational safety and health culture and safety awareness activities

The facility’s OSH approach is also reflected in routine practice, such as OSH training for volunteers and interns (documented in October 2025) and safety training initiatives for residents, including on fire safety and evacuation training.⁶ On the employee representation side, the presence of social labour inspectors was described as having strengthened day-to-day monitoring and enabled the timely remediation of technical deficiencies. The interviewees reported an absence of workplace accidents and highlighted routine OSH provisions, including entitlements to work clothing and footwear, with a procedure allowing for early replacement where justified by the OSH specialist. The interviewees highlighted improved workload organisation, such as adherence to work schedules, the absence of overtime and adequate time for recovery, while also noting low levels of sickness absence.

Success factors and challenges

A key enabling factor in the DPS Toruń case is that the evaluation standards operate as a continuous monitoring-and-response mechanism, rather than as a one-off assessment. They are embedded within an institutionalised cycle of communication between staff and management, including regular small-group meetings, and an open-door approach that sustains continuous feedback loops and facilitates timely corrective action. This model has been substantially reinforced since a leadership change in January 2025, which the staff representative described as a turning point. The new director’s management style is characterised by openness to dialogue and efforts to ensure that employee feedback results in visible follow-up (‘there is a reaction and information about the reaction’), thereby strengthening trust and participation.

At the same time, the interviews suggested that the current governance model was underpinned by an earlier institutional development: namely, the establishment of an assertive inter-company trade union in 2020, which brought OSH-related deficits, such as the lack of assistive equipment for safe resident transfers, to the attention of both the organisation and the municipality and created sustained pressure for change. Crucially, the union’s approach was described not as oppositional ‘for its own sake’, but as solution-oriented, which appears to have reduced the costs of conflict and increased the scope for joint problem-solving with management.

A further enabling factor is the capacity to translate monitoring findings into the mobilisation of external resource. Joint efforts between management and the union have reportedly supported access to external funding and policy-level advocacy, thus leading to concrete OSH-related improvements. Finally, the facility’s approach to staff shortages combines recruitment with competence development.

⁶ More information is available at: <https://torun.naszdzps.pl/n%2Cszkolenie-dla-mieszkancow-z-zakresu-bezpieczenstwa-przeciwpozarowego-i-bezpiecznej-ewakuacji>

Cooperation with the local employment office is complemented by a broad training package, which reflects a management policy oriented towards developing staff capabilities rather than relying solely on hiring already qualified workers.

At the same time, several challenges have limited the intervention's scope and sustainability. The interviews highlighted persistent difficulties in recruiting and retaining suitable staff, including nurses, reflecting the structurally tight labour market for care workers and the comparatively limited financial attractiveness of jobs in residential care. These challenges are compounded by an occupational attractiveness gap that is both material and symbolic. Wages are described as lower than in hospitals, where nursing staff can earn more, while the work is perceived as more physically and psychologically demanding. At the same time, the sector continues to suffer from a negative public image that further discourages entry. The workforce profile adds additional pressure, as care staff are predominantly approaching retirement age, which increases their ergonomic vulnerability and the likelihood of workforce losses due to retirement. These facility-level constraints are reinforced by broader demographic trends. Population ageing and a shrinking pool of working-age people are expected to exacerbate labour shortages while simultaneously increasing demand for LTC, thereby intensifying workload pressures in institutional settings. Operationally, the facility faces an increasing care burden as the number of high-dependency residents grows. Many require full assistance with bathing, feeding, transfers and medical appointments, thus contributing to sustained physical demands and psychosocial strain, including exposure to verbal and physical aggression and an increased risk of burnout.

Finally, the interviews identified an important governance vulnerability. Because the intervention relies heavily on a dialogue-based management model built on trust, interviewees expressed concern that a future change in leadership could shift the organisational culture away from participation and continuous feedback, thereby potentially weakening the very mechanism for identifying and addressing risks.

Transferability

The DPS Toruń case is highly transferable because it is built around core OSH governance functions that are applicable to residential care in any Member State, including continuous monitoring of care standards and working conditions, prioritisation of the most acute risks, especially those related to manual handling and psychosocial factors, and the use of evaluation findings to inform training, work organisation and investments in equipment. In practice, this is closely aligned with the rationale behind EU OSH approaches: employers are required to ensure workers' safety and health, carry out risk assessments and involve workers and/or their representatives in OSH-related matters – principles embedded in the OSH Framework Directive (EU-OSHA, 2021) and related EU-OSHA guidance.

Transferability is further strengthened because the intervention addresses structural patterns that are common across LTC systems in the EU, including staff shortages, an ageing workforce and difficult working conditions, where collective bargaining and worker voice can play a decisive role in staff retention and risk prevention. Eurofound's mapping of the LTC workforce (Eurofound, 2020) underlines the fact that these workforce constraints and challenges in working conditions are not country-specific, which increases the relevance of solutions that combine prevention, participation and workforce support across all Member States.

Successful replication would require adapting the DPS Toruń model to national financing and governance arrangements. The interviews revealed that the evaluation system at DPS Toruń works partly because it is accompanied by (i) mobilisation of external resources for aspects such as equipment and training, and (ii) strong facility-level social dialogue, including union-backed advocacy, which even extends to debates on statutory staffing ratios. In Member States where residential care is financed through different means, such as insurance-based schemes, stronger regional purchasing or different municipal competences, transfer would therefore require a local equivalent of DPS Toruń's 'resource pathway': a clear mechanism for turning evaluation findings into funded improvements.

A practical way to frame transferability is to distinguish between (i) measures that can be replicated immediately at facility level, and (ii) measures that benefit from systemic support. Facility-level replication is feasible even without national programmes; any residential care provider can establish a continuous evaluation cycle, define priority OSH domains such as manual handling, MSDs, psychosocial risks, staffing, work organisation, training needs and equipment shortages, and institutionalise worker participation through systems such as joint committees with staff and worker representatives, so that findings translate into a targeted action plan. This is especially relevant given

EU-OSHA's recent review emphasising heavy workload, manual handling and insufficient training as major drivers of musculoskeletal risk in health and social care (EU-OSHA, 2025).

System-level support becomes crucial where the intervention requires investments that exceed facility-level budgets, such as lifting devices, redesign of work processes, sustained training capacity and staffing upgrades. Transferability is most feasible when prevention and health-promotion resources are earmarked (ring-fenced) and linked to measurable objectives, while administrative burdens are kept low and accountability and evaluability are built in from the outset, including baseline and follow-up indicators such as sickness absence, turnover, holiday duration and staff feedback. This matters for Toruń-style replication, because continuous monitoring only changes outcomes when accompanied by implementation capacity and financing; otherwise, evaluation risks becoming a documentation exercise.

Finally, EU-level policy framing can facilitate transfer. The European Care Strategy explicitly targets improvements to care services and the situation of professional carers, including working conditions and work-life balance, while the Commission has continued to review how EU labour standards apply in LTC contexts (European Commission, 2024). This provides a useful 'policy umbrella' for transfer: Member States and regional authorities can present continuous evaluation standards in residential care as an operational instrument to deliver the objectives of the European Care Strategy – quality, workforce sustainability and prevention – while facilities can align their internal indicators with the type of metrics increasingly expected by policymakers for monitoring progress.

In summary, the DPS Toruń approach is transferable as a low-regret OSH governance model (continuous evaluation + participation + targeted action), but its effectiveness elsewhere will depend on two conditions: (1) institutionalising worker involvement and social dialogue so that priorities are credible and actionable; and (2) ensuring a predictable route from identified risks to financed improvements, especially for ergonomic equipment and structured training, so that evaluation produces measurable results.

References

- EU-OSHA – European Agency for Safety and Health at Work (2021). *The OSH Framework Directive*. <https://osha.europa.eu/en/legislation/directives/the-osh-framework-directive/the-osh-framework-directive-introduction>
- EU-OSHA – European Agency for Safety and Health at Work (2025). *Musculoskeletal Health and risk factors in the HeSCare sector – a review of existing information*. <https://osha.europa.eu/en/highlights/musculoskeletal-health-health-and-social-care-sector>
- Eurofound (2020). *Long-term care workforce: Employment and working conditions*. Publications Office of the European Union. <https://www.eurofound.europa.eu/en/publications/all/long-term-care-workforce-employment-and-working-conditions>
- European Commission, Directorate-General for Employment, Social Affairs and Inclusion (2024). *New reports reviewing application of EU standards governing working conditions in the long-term care sector*. https://employment-social-affairs.ec.europa.eu/news/new-reports-reviewing-application-eu-standards-governing-working-conditions-long-term-care-sector-2024-11-29_en
- Gmina Miasta Toruń (2024). *Zdrowi i aktywni 2*. <https://torun.pl/pl/zdrowi-i-aktywni-2>

Authors: Dominik Owczarek — Institute of Public Affairs (Poland).

Project management: Lorenzo Munar — European Agency for Safety and Health at Work (EU-OSHA).

This case study was commissioned by the European Agency for Safety and Health at Work (EU-OSHA). Its contents, including any opinions and/or conclusions expressed, are those of the authors alone and do not necessarily reflect the views of EU-OSHA.

Neither the European Agency for Safety and Health at Work nor any person acting on behalf of the agency is responsible for the use that might be made of the above information.

© European Agency for Safety and Health at Work, 2026

Reproduction is authorised provided the source is acknowledged.

For any use or reproduction of photos or other material that is not under the copyright of the European Agency for Safety and Health at Work, permission must be sought directly from the copyright holders.