THE ACCOMPLISHMENT OF WORK

What We Think Happens, What Actually Happens & Risk Multipliers

By Scott L. DeBow

"When two or more employers depend on each other to accomplish work, a space exists between them filled by employees charged with actually completing the work," writes Scott DeBow. This space between employers is the subject of DeBow's upcoming book, *Safety Management Systems in a Joint-Employer Environment*. In this excerpt of the book's first chapter, DeBow discusses the role of communication in the joint-employer work environment.

There is such great dignity in work, and safety is deeply personal. There is a certain nobility and pride in using our minds and hands alongside others to accomplish important work together, especially since it is connected to the creation and care of things we need now and things we need for the future. With respect to our agreed-upon moral imperative that "no one gets hurt today," we each have our own unique and formative experiences that continue to shape and influence our preferred views on the best ways to accomplish work.

For me, these experiences were formed from a father who was quite the hybrid of an engineering mindset and a hands-on mechanic. I grew up observing that all tools have their place, and you clean them before you put them away. "A place for everything, and everything has a place," he would say, really echoing what my grandfather taught him. Some of the concepts of *safe work* rooted in this approach often favored overthinking, and new or alternative methods were viewed with a high degree of skepticism and often dismissed. There was value in delaying the completion of a task until everything was just right. However, my father-in-law grew up in an environment where not being able to fix your neighbor's tractor meant fields didn't get plowed, people didn't get paid, and there was less food on the table. In other words, he learned to thrive on creativity in problem-solving with any available resource, and greater risk was a readily accepted value as long as it kept work moving.

Both of these examples have taught me that our current understanding of work is powerfully connected to past experiences and is connected to the people who influenced our approach to the concept of work before we were even old enough to be legally employed. These lessons have shaped and changed my approach to safety over my career. I've become acutely aware that without the highest levels of respect and consideration for the workforce, a technically accurate but poorly delivered safety message can aim a finger at the worker as if to say, "Your parent/teacher/coach/caregiver taught you the wrong procedure, and you're still doing it wrong." With this in mind, do you think that even a sincere and well-intentioned safety message can strike the wrong chord on a personal level, destroy trust, and tune out future messaging with those we depend on to accomplish work? Absolutely! The point of my story is that neither approach is necessarily wrong, better than, or more right than the other.

Better safety comes down to communicating better care for our workforce to anyone who has influence over the safety and well-being of others (e.g., safety leaders). This is critically important for us to understand, especially since many of our ideas and attempts at safety fail to connect at the human level needed to create trust and reliable communications. In this writer's humble opinion, nowhere is this more evident than in the increasingly common joint-employer work environment, where work is accomplished by two or more employers using permanent, temporary, and/or contract labor.

Yes, there is much dignity in work, and safety is deeply personal, requiring care and understanding of what creates an open environment for communications specific to the needs of the workforce. A technically accurate and factually supported safety message on the right way to do things will strike a chord at some level but will probably feel sharp or fall flat if it does not consider the unique risks and communication needs specific to that workforce.

Safety performance really comes down to people and how we communicate and, as it relates to safety in a joint-employer environment, how we ensure effective communication and risk management practices between those arranging for the work to be completed (corporate) and those actually completing the work (workforce). In these joint-employer environments, the common systems we rely on most heavily in order for *things to go right* are fragile. Simple things, such as communicating a shortage of PPE that affects temporary workers can easily be disconnected from the managers responsible for this workplace activity (and who could solve this problem) and can be disconnected from the staffing company's knowledge and awareness that these new risks are impacting their employees. Meanwhile, where does this leave the worker? Far too often that temporary worker is performing job tasks at a greater degree of risk, with the incident reporting process serving as the only indicator relied upon to reengage leadership's attention.

For those of us charged with any degree of safety management where contingent labor (temporary, contract) is part of the labor strategy, it is important first to consider how we are actually connected to what we think is going on in our workforce. What tells us that risk and safety are at acceptable levels, when those levels fluctuate, and when they require intervention? Are the safety management systems capable of continually monitoring the levels of risk and able to address the hazards experienced by the workforce? How confident are we that the boxes checked on an orientation checklist for temporary workers translate into the needed safety communications when things go from normal to abnormal, such as whether work can continue if we run out of certain PPE?

Nestled in between the two corporate entities (primary and host employers) and the temporary workers performing the work are operations managers and supervisors who represent both employers that have inherited the work system and are expected to deliver acceptable safety outcomes. They are in a prime position to anticipate error, communicate change, and help leadership of both employers reliably answer the question "Is work being completed as we agreed and anticipated?" However, they are rarely equipped to effectively manage a joint-employer workforce, nor are they trained in the additional complexities, risks and

vulnerabilities specific to a joint-employer environment. Effective safety will not outlive good intentions, much less live outside of a reliable system.

Traditionally, the bar has been set fairly low when it comes to expectations between how two employers, both responsible to varying degrees for the safety of each other's employees, will work together to reliably create safe working conditions. When it comes to safety in a joint-employer environment, there is the work we think is happening, and then there is the work that is actually happening on the production floor. In other words, there is a state of *imagined performance* at the corporate levels, where agreements are signed and the scope of work is outlined, that is quite different from what is experienced at the production level. The problem with the history of low expectations within safety performance in a joint-employer environment is that there is little emphasis on, knowledge about or capability for connecting corporate expectations with the reality of what is actually needed to enable safe, reliable work.

A joint-employer arrangement adds complexity to a traditional work arrangement. Not addressing this for a joint-employer environment creates a risk multiplier for existing hazards, behaviors and conditions. Risk is multiplied in these work settings from the beginning because the focus is on a myriad of legal and compliance-related qualifications necessary to begin the working relationship, often to satisfy and show diligence in areas such as contracts, insurance and the general procurement process. The challenge is that the heightened level of corporate emphasis between joint employers at the beginning of the process does not deliver effective end-to-end risk practices throughout the work cycle. Often, only injury and incident reports serve as *performance indicators*, but these are still disconnected from the true state of risk experienced by the workers.

I don't mean to convey that well-written contracts, insurance coverage and a balanced procurement process are not important since these provide the opportunity for both employers to demonstrate diligence and agreement about the scope of work and who is responsible for what type of activities, such as limits on training and provision of PPE. But it is important to understand that this is where risk first enters the workforce in these joint-employer environments, and

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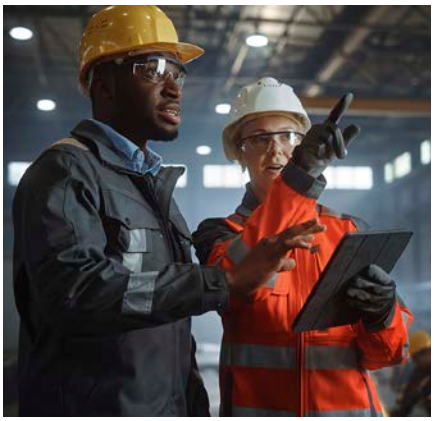

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there are many assumptions that a good contract, the right insurance coverage and a cost-saving procurement process will effectively create downstream safety capabilities where work is actually taking place.

Here's a quick breakdown of the general process, described in a manner that highlights goals and competing interests.

1.a. Host employer (employer needing a staffing/labor provider): This employer needs a supplemental workforce to accomplish its work, transferring varying degrees of risk and operational costs in order to achieve its financial goals.

1.b. Primary employer (staffing/labor provider): This employer is sales driven and competing with multiple other staffing firms. There is intense and constant pressure to provide higher levels of service, assume higher levels of risk and offer lower costs for service that can still deliver what the client wants while simultaneously ensuring it can cover the costs of the risks it is preparing to assume.

2. General discovery occurs where the primary and host employers both perform basic aspects of diligence, such as the staffing firm completing a safety compliance checklist to satisfy both regulatory and insurance requirements and confirming that general requirements (training, forklift operation, fall protection, HazCom, etc.) are in place at the host employer. Other areas, such as examining credit risk, also are often part of this process. While the approach to general safety evaluation is simple and compliance based, it is carried out during a process where those responsible for completing it are also those who stand to gain by *winning business* (primary/staffing) or *finding a lower cost provider* (host/client). They are rarely the ones responsible for safety performance. As a result, there is a healthy dose of bias in the process that is combined with lower levels of safety capability. Confirming safe adherence to required programs that disclose the types of hazards and necessary risk controls in the work environment often are not part of the discovery process.

3.a. Work begins when temporary workers are screened and hired by the primary employer according to the host employer's requirements. Temporary workers are assigned to positions and go through general safety training from the primary employer as well as site-specific training from the host employer. Orientation and training often operate at a bare bones level, especially in higher turnover production environments.

3.b. Lower levels of risk awareness (i.e., knowledge of things that can hurt me or others) combine with other factors such as a new environment, production pressures and cultural expectations from previous employers that often run counter to the safety ideals of the new employers. Added to this are the perceptions (real or imagined) of what it takes to both perform and keep your job. This mix creates a potentially lethal brew.

4.a. Risks combine and multiply when the corporate procurement and contractual process leaves the leadership of both employers believing that safety will be practiced as it should be. Independent of any significant event or loss, they are unaware of actual levels of latent risk because the current process does not create strategic safety interventions and communication. The practices of anticipating error and actively monitoring and managing risks once work has started are often absent.

4.b. Actual work practices for tasks critical to safety, such as lockout/tagout, begin to *drift* and operate outside of regulatory requirements and the written programs. Unsafe practices are normalized. *Note:* Though there may not have been any significant injury or event to highlight actual levels of risk, neither is there any joint risk assessment process or communication at established intervals to ensure adherence to critical safety practices.

The above points indicate a real need for progressive thinking in joint-employer safety. Unfortunately, the loss experience in this industry is punctuated through numerous tragedies and workplace fatalities involving temporary workers, such as the fatality incident of a young temporary worker 90 minutes into the first day of his first job. This incident, in August 2012, became one of the more visible OSHA investigations in recent years and further validated the obvious need for critical improvements to safety in a joint-employer environment (OSHA, 2013). As you read through the brief list of circumstances below, keep in mind what each employer believed was occurring versus what was actually happening at the production level.

1. Administrative methods and controls were in place, such as written contracts and an agreement between the employers about the nature and scope of work, the types of assignments and so on. While there was administrative acknowledgment of hazards and controls related to lockout/tagout, this did not translate into effective worker knowledge and awareness or supervisor practices in workforce management.

2. Both employers had done little to familiarize themselves with the actual work practices required by the agreed-upon scope and nature of work and the actual risks and hazards experienced by employees.

3. There were no formal or informal methods to verify that risk controls for work practices critical to safety (such as lockout/tagout) were in place. Worker knowledge of the types of hazards and how to deal with them was absent.

4. Temporary worker profile: 21 years old, first day in a new work environment. This combined with inadequate hazard training, lower levels of risk awareness and a poor understanding of how he could get hurt led to an unfortunate fatality.

Note: The reference to lower levels of risk awareness and perception are a reflection of system management and not in any way a reflection of the capability of the worker. I believe this could have happened to my son had he been placed in the same situation.

No one showed up for work that day intending for someone to suffer so great a harm or with the intent to bypass known safety practices to the extent that a fatality would happen. But one did happen. A brother departed, a son did not return home, and a child will only know a father through the stories of others.

Almost as tragic is how easy it should be for us to vastly improve safety. In this fatality, and most others, we are not talking about unknown risks or having to invent new methods for the control of hazardous energy or technology. For decades, consensus standards such as ANSI B11 (B11-2020) and the regulatory standards for controlling hazardous energy and lockout/tagout (29 CFR 1910.147) have outlined the necessary risk-based approach along with applicable regulatory requirements. The gaps exist among ineffective safety management systems, an overreliance of joint employers on the effectiveness of their underwriting and compliance agreements and the assumption that the absence of injuries equates to the presence of safety at the worker level—any worker, traditional or temporary.

We are simply talking about cementing higher level expectations with better risk interventions and safety practices that acknowledge the increasing use of a contingent workforce as part of a needed labor pool, and the need for a strategy that addresses the unique risks specific to these labor arrangements.

Chapter 1 Touch Points

1. Accomplishing work between two or more employers (joint employers) introduces new risks for employers to consider and manage and multiplies the risks already present in the workforce. While there are examples of primary and host employers collaborating and managing these risks well, there are far too many examples of failure involving a serious injury or fatality. Traditional industry expectations and safer work practices are unfortunately minimal.

2. Safety today will—and I believe always will—boil down to how we value people, as well as how we prioritize communications. In a joint-employer environment, safety communications are emphasized and prioritized most often at the beginning of the employers' relationship (via contracts, insurance, procurement) or after a failure occurs. Both the value placed on workers and the communications required downstream of what corporate entities agree to are insufficient.

3. Communications are fragile in a joint-employer environment. Change, such as leadership turnover, can happen frequently and suddenly. When specific management of change practices are not in place between the employers, this unfortunately produces a powerful risk multiplier since both employers depend on reliability and dependability in risk communications.

4. While it seems everyone desires and expects great safety performance in a joint-employer environment, there are many systemic obstacles and barriers set in place through the traditional process, and these are passed along for the operations teams to manage. What our leadership needs most is a fresh perspective and elevated expectations. Fortunately, we have many rich examples for this industry to draw on to create a safer future. **PSJ**

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