

SAFETY CULTURE ATTRIBUTES TABLE

On August 17, 2005, the NRC conducted a public meeting on the agency's initiatives to enhance the Reactor Oversight Process (ROP) to more fully address safety culture. The NRC staff asked stakeholders to provide suggestions/comments on the draft Safety Culture Attributes Table (Table) on a feedback form located on the Safety Culture web page. The Table is comprised of safety culture attributes, elements, potential inspection information, and potential measures. The Table was developed using a wide range of sources including safety culture information from the Institute of Nuclear Power Operations, nuclear and other industry sources, the International Atomic Energy Agency, the Nuclear Energy Agency, nuclear regulators from other countries, academia, and safety culture knowledge and experience of the NRC staff.

The attached Table reflects feedback from internal and external stakeholders. In addition, the Table was screened based on the fundamental principles of the ROP (objective, risk-informed, predictable, and understandable) and other screening criteria.

In reviewing the Table, please note the following:

- (1) The Table is not an inspection procedure. However, aspects of the Table may be referred to by inspectors as they develop a finding to gain potential insights into features of a licensee's safety culture relative to the finding.
- (2) The safety culture measures are not performance indicators but rather are meant to be data that could be used by inspectors or others to focus on areas of potential concern for additional review.
- (3) No individual Safety Culture Element can provide sufficient information about a licensee's safety culture. However, in the aggregate, elements may provide information about potential safety culture issues.

The contents of the Table and its use will be discussed at the October 26th public meeting.

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SAFETY CULTURE ATTRIBUTES TABLE

SAFETY CULTURE ATTRIBUTE	SAFETY CULTURE ELEMENT	POTENTIAL SAFETY CULTURE INSPECTION INFORMATION	POTENTIAL SAFETY CULTURE MEASURE
An inherent characteristic, quality, or property that is critical to a licensee's safety culture.	A specific factor, process, or process outcome that can either be inspected or measured and that can be used to assess a licensee's performance with respect to the Safety Culture Attribute(s).	Qualitative information that is acquired from an inspection to assess change or performance of a Safety Culture Element.	Quantifiable information that is acquired through an inspection (e.g., that can be counted, trended or noted) which can be used to assess change or performance of a Safety Culture Element.
ORGANIZATIONAL SAFETY AND ACCOUNTABILITY	SAFETY POLICIES (E.G., EMPHASIS ON SAFETY FIRST)	A vision/mission statement that addresses safety is clearly visible, understood, and applied	
		Personnel understand safety policies and that safety is of highest priority	
		Management actions embody safety culture principles	Trends of U.S. Nuclear Regulatory Commission (NRC) allegations or issues raised to the licensee's alternative process (AP) for raising concerns (e.g. an Employee Concerns Program (ECP)) related to repetitive equipment deficiencies and/or human performance problems
		There are documents related to safety culture and safety conscious work environment (SCWE) (e.g., emphasizing commitment to safety over production) with evidence that they are communicated and reinforced	
		Concerns raised through the corrective action program (CAP) show implications of placing safety over production	Trend of production over safety concerns raised to the NRC allegation program or the licensee's AP
		Corporate and station business plans place a high value on nuclear safety and are consistent with each other	
		Work teams/groups across the plant are aligned with plant-specific safety policies and initiatives	
		Corporate goals for nuclear safety are established and monitored	
Board members and corporate officers demonstrate nuclear safety including visiting sites to assess material condition and management effectiveness first-hand			

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		Offsite personnel, including Board members, senior corporate executives, and others demonstrate their understanding of the unique safety requirements of nuclear technology and operations	
		Corporate and plant nuclear oversight groups perform objective assessments that are of appropriate scope and depth	
		The licensee ensures contractors have safety policies/programs commensurate with those established for onsite personnel or they follow those of the licensee	
	ACCOUNTABILITY AND INCENTIVE PROGRAMS	Individual roles & responsibilities as related to safety functions are clearly defined and understood	
		Personnel have the authority to meet their safety-related responsibilities	
		Management observation programs are used to develop safety improvements	
		Managers are present during critical activities, when appropriate, and demonstrate a proper safety focus	
		Peers hold each other accountable for safety	
		Performance assessments of personnel include safety and SCWE	
		Corporate and plant support groups, such as human resources, legal, labor relations, and business and financial planning, understand their roles in ensuring safety	
		Personnel are rewarded for safety behaviors and achievements (e.g., a "Good Catch" recognition program exists to recognize individuals who identify safety issues)	
		Senior management incentive programs reward actions to promote long-term plant safety and performance	
		Single-point accountability is maintained for important safety decisions, allowing for ongoing assessment and feedback as circumstances unfold	

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	ADEQUATE RESOURCES	Resources are adequate to support initial, requalification, and on-the-job training and technical competency	Percentage of personnel in American National Standards Institute (ANSI) 3.1 slots who have fulfilled their required qualification
			Percent of training staff who are contractors
		Resources are adequate to maintain plant calculations, drawings, final safety analysis reports (FSARs), and other design and licensing basis documents	Trend in engineering backlog (e.g., FSAR updates, drawing updates)
		Resources are adequate to provide necessary tools, equipment, and facilities to support plant activities	
		Resources provide for sufficient qualified personnel and training to plan and perform safety-related activities	Percentage of positions identified in ANSI 3.1 that are open
		Resources are adequate to support necessary capital improvements	Trend in deferred capital improvements
		Resources are adequate to support necessary maintenance and keep backlogs to manageable levels	Trend in preventative maintenance backlog
			Trend in corrective maintenance backlog
			Percentage of plant modifications that have been disapproved or deferred
			Percentage of total maintenance that is repeat (rework)
		Resources are adequate to limit temporary modifications	Percentage of safety-related systems that contain temporary modifications
			Average age and number of temporary modifications
		Resources are adequate to minimize operator work-arounds	Average age and number of operator work-arounds and control room deficiencies
			Average age and number of control room indications out of service
		Resources are adequate to keep procedure change backlogs at manageable levels	Trend of procedure change backlog
Resources are adequate to ensure that working hours are within NRC guidelines	Average number of overtime hours per person by department		

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			Annual number of approved deviations from the working hours guidance
			Annual number of NRC allegations, AP, and CAP entries related to safety implications of excessive overtime
			Annual number of significant conditions adverse to quality (SCAQs) and conditions adverse to quality (CAQs) with fatigue identified as one of the root or apparent causes
			Annual number of self-declarations related to fatigue that are denied
		Resources are adequate to maintain simulator fidelity	Average age and number of open simulator discrepancies
	ORGANIZATIONAL CHANGE MANAGEMENT	Organizational changes consider the potential impacts on safety performance	
		There is a systematic process for planning, implementing, and evaluating the consequences of organizational change, which is used to maintain trust in the organization	
		The bases of decisions for major organizational changes that may impact safety are communicated to staff	
		The effectiveness of management communications related to organizational changes that may impact safety is assessed	
		There is a systematic process for evaluating the safety impact of organizational changes and evidence that the process is used	

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SAFETY CONSCIOUS WORK ENVIRONMENT (SCWE)	SCWE POLICIES	SCWE is assessed using appropriate performance measures and actions are taken in response to negative results	Frequency of SCWE assessments/surveys
		Personnel understand their responsibilities, and take actions, to raise issues, challenge unsafe acts, participate in the resolution of issues, and clearly communicate safety issues to management	
		Management ensures personnel receive SCWE/AP training	Percentage of personnel who have received initial SCWE/AP training
			Percentage of personnel who receive refresher SCWE/AP training per year
	WILLINGNESS TO RAISE CONCERNS	Management actions and communication encourage challenging unsafe acts, voicing dissenting views, raising safety issues, and reporting anomalies	Annual number of NRC allegations of chilling effect
			Annual total number of NRC allegations
		There is evidence that personnel feel free to raise safety issues	
		Personnel raise nuclear safety concerns without fear of retaliation	
		Self-reporting of errors is encouraged and there is evidence that personnel feel free to do so	
	ALTERNATIVE PROCESS (AP) FOR RAISING CONCERNS (I.E., ALTERNATIVE TO THE CORRECTIVE ACTION PROGRAM (CAP) OR LINE MANAGEMENT)	An AP for raising concerns (e.g., an ECP, ombudsman, confidential hotline) is effectively implemented (e.g., confidential, accessible, includes an appeals process, results in timely and appropriate problem resolution)	Trend in the number or type of NRC allegations/number or type of AP concerns
			There is evidence that personnel feel free to use the AP when necessary
		Number of AP decisions that are appealed and overturned	
		Annual number of NRC allegations regarding the effectiveness and confidentiality of the AP	
		Personnel are aware of the AP and NRC regulations regarding employee protection	Percentage of AP resolutions that meet timeliness goals

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	PREVENTING AND DETECTING RETALIATION	Disciplinary actions are reviewed and actions are taken to prevent a chilling effect, when necessary	
		Personnel at all levels of the organization are aware of zero tolerance for retaliation	Trend of AP allegations of retaliation
			Annual number of NRC allegations of retaliation
			Annual number of substantiated retaliation issues in AP and from NRC
		Management collects and assesses information related to alleged incidents of retaliation for raising safety concerns and takes corrective action, when necessary	Trend of harassment, intimidation, retaliation, and discrimination (HIRD) concerns submitted to the AP and annual number of HIRD allegations received by the NRC

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ORGANIZATIONAL LEARNING AND ASSESSMENT	INTERNAL AND EXTERNAL OPERATING EXPERIENCE (OE)	Analyses are conducted of internal and external OE	Percentage of OE reports completed on time by department
		Training programs make use of OE	
		Searches of relevant OE are conducted when making significant modifications to procedures or equipment and before conducting risk-significant work	
		Applicable OE is reviewed with personnel before beginning a work activity	
		Evaluations of OE are used to make safety improvements that are responsive and implemented in a time frame commensurate with their safety significance	Percentage of OE evaluations that result in safety improvements or corrective actions
		There is evidence that personnel use OE to make safety improvements	Annual number of NRC findings and licensee event reports (LERs) attributed to inadequate responses to previous OE reviews
		OE and/or other safety information is systematically communicated to plant personnel	Trend of condition reports written to review systems and procedures against OE
	SELF-ASSESSMENT PROCESS	The licensee's internal nuclear safety indicators are tracked/trended and corrective action is taken as needed	
		Self-assessments are of adequate frequency and scope (e.g., identify latent conditions), self-critical, and result in necessary actions to maintain safety performance	Trend of departmental/cross-functional self-assessments performed each year
			Trend of repeat findings in self-assessments
			Percentage of recommendations implemented as result of self-assessments
		External experts are used on self-assessment teams as needed	
		Self-assessment reports are communicated to all personnel	
	Periodic assessments are conducted to evaluate the effectiveness of internal and external oversight groups		
PROBLEM IDENTIFICATION AND RESOLUTION (PI&R)/CORRECTIVE ACTION PROGRAM (CAP)		Trend of PI&R NRC inspection findings	

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		All SCAQs and CAQs are entered into the CAP	Trend of inspection findings with PI&R cross-cutting aspects
		Problems are identified completely, accurately, and in a timely manner commensurate with their significance and ease of discovery	Percentage of self-identified SCAQs and CAQs versus those that are self-revealing or identified by an external organization
		Root cause assessments identify human performance issues as applicable	Trend of inspection findings with human performance cross-cutting aspects
		Safety equipment performance and human performance are tracked and evaluated at specified intervals to identify and address negative trends	
		Operability/reportability issues are evaluated and dispositioned	
		Problems are classified, prioritized, and resolved commensurate with their actual or potential safety significance	
		Daily reviews of condition reports (CRs) identify the significance and extent of condition of each issue reviewed	
		Root and contributing causes are identified for problems involving a SCAQ	
		Root cause review boards are comprised of personnel with root cause analysis training and relevant technical expertise	
		Management challenges the effectiveness of root cause evaluations (e.g., Corrective Action Review Board (CARB), Plant Operating Review Committee (PORC)) with a focus on safety	
		Corrective actions are completed in a timely manner commensurate with the safety significance, scope, and complexity of the issue	
		The repetitiveness of corrective action entries is evaluated and the results are considered during issue prioritization	Trend in corrective action program backlog (by significance level), both evaluations and corrective actions
			Trend and significance of repeat events
			Ratio of repeat corrective action issues to total issues

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		Issues in the CAP are periodically reviewed to identify entries that, in the aggregate, may be indicative of a safety issue	
		Results from all types of assessments are integrated periodically to provide a comprehensive view of safety performance	
		The disposition of corrective action issues is accessible to the originator of problem report	
		Feedback is sought from the originator on effectiveness of actions, and results of feedback are assessed and acted upon	Percentage of anonymous CRs
	CONTINUOUS LEARNING ENVIRONMENT	Personnel participate in job-related continuing education and staff rotations are provided for breadth of experience	
		Training ensures technical competency	
		Training is provided on human performance tools (e.g., stop, think, act, review (STAR), self-check, peer-check, contingency plans, post-job review)	
		Site training incorporates new and emerging issues and OE	
		Personnel use best practices from groups outside their organizational unit	
		An effective process exists for the transfer of critical information and decision making from departing personnel	
		Personnel errors are handled as an opportunity for learning and improvement	
		Operator training is effective	
		Simulator fidelity is maintained	Average age and number of open simulator discrepancies
		Managers and supervisors are personally involved in training that consistently reinforces expected safety behaviors	
		Individuals are removed from their duties when gaps in critical knowledge, skills, and abilities are identified	

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		Benchmarking is actively used to develop insights regarding improvements that could be made to programs and processes	Trend in number of good practices and lessons learned identified from benchmarking activities that are internally communicated or selected for further action Rate of benchmarking trips by each organizational group
		The results of benchmarking activities are evaluated and specific recommendations are developed, communicated, and implemented	
		Corporate personnel stay informed of and communicate to plant management relevant external influences on the industry and industry safety initiatives	

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WORKING PLANNING AND HUMAN PERFORMANCE	WORK CONTROL	Work planning and coordination consider risk insights, defense-in-depth, OE, and compensatory actions	
		Work is planned and coordinated to prevent unintended interactions between jobs/activities	
		Work planning seeks out and relies on necessary technical expertise and knowledge (e.g., corporate specialists, vendors, and in-house experts)	
		Plant calculations, drawings, FSARs, and other design and licensing basis documents, which are used in work planning, are up-to-date	Trend in engineering backlogs (e.g., FSAR updates)
		Work planning limits temporary modifications	Average age and number of temporary modifications
			Percentage of safety-related system that contain temporary modifications
		Work planning ensures that operator work-arounds are minimized.	Average age and number of operator work-arounds and control room deficiencies
		Changes to work orders/plans for risk significant activities are given appropriate organizational level of review to consider the impact on safety	
		Preventative maintenance is performed at its nominal frequency	Annual number of preventative maintenance deferrals
		Preventative maintenance schedules, methods, and work instructions are updated in response to OE, design changes, and vendor bulletins	
		Maintenance is performed on a predictive basis to avoid the need for corrective maintenance on a reactive basis	Ratio of corrective maintenance versus preventative maintenance
		Preventative maintenance activities are planned to limit equipment unavailability	Number of Generic Letter 91-18 degraded components not returned to design performance by the next outage
Annual number of maintenance rule findings			
Annual number of maintenance rule systems in A1 category			

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		Work planning and coordination consider the sequencing of system availability and limits system unavailability	Trend in the number of work planning and implementation deficiencies entered into the CAP
		Work planning and coordination consider the benefits of doing the task versus potential radiological exposure to personnel	Trend in the number of personnel contamination events
		Work planning and coordination ensure personnel have appropriate qualifications, training, procedures, job aids, instructions (e.g., expected outcomes, job conditions, hold points, contingencies for work, and stop work criteria), clothing, tools, and equipment	
		Reliance on manual actions is minimized	
		Work status and emerging issues are communicated among personnel	
		On-line corrective maintenance considers risk	Trend in on-line corrective maintenance backlogs
			Trend in on-line elective maintenance backlogs
			Trend of maintenance backlog involving systems that are risk-significant
			Annual number of entries into technical specifications (e.g., number and trend of unplanned Limiting Conditions for Operations (LCO) entries)
			Annual number of repeat equipment failures in maintenance rule systems
			Annual amount of time spent in the increased (e.g., "Yellow") risk category for on-line maintenance
		Strong emphasis is placed on industrial and work environment safety	Annual number of Occupational Safety and Health Administration (OSHA) recordables and reportables
	SYSTEMATIC DECISION-MAKING	There is evidence of conservative decision-making (e.g., redundant fuel oil suction line to emergency diesel generators is installed because probabilistic risk assessment (PRA) shows substantial improvement in safety for reasonable cost)	

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		Management decisions demonstrate a commitment to safety over production	
		Safety significant decisions are conducted using a systematic process, are made at the appropriate organizational levels, with the relevant expertise, and consider potential consequences	
		Systematic decision-making prevents unauthorized tests or experiments	
		Effectiveness reviews of safety significant decisions are conducted to verify the validity of the underlying assumptions, identify possible unintended consequences, and determine how to improve future decisions	
		Changes that are screened per 10 CFR 50.59 consider safety issues and are based on conservative assumptions	
		Steps are taken to ensure that sufficient design margins are maintained when making changes to plant equipment, procedures, and personnel	
		Risk insights are incorporated into the decision-making process	
		Operability evaluations include the identification and assessment of all potential safety issues and are based on conservative assumptions	Annual number of NRC findings related to inadequate risk evaluations (e.g., 10 CFR 50.65(a)(4))
			Annual number of NRC findings related to inadequate systematic decision making (e.g., operability evaluations, 10 CFR 50.59 evaluations)
		Safety-related decisions and their bases are communicated to affected personnel	
		Affected personnel are solicited for their views on safety-related decisions	
		Equipment performance is monitored, periodically assessed, and actions are taken to maintain long-term reliability	Percentage of risk significant equipment that is assessed periodically (e.g., system health reports)

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		Pre-job briefs (e.g., expected actions, responsibilities, compensatory actions, and contingencies) and/or mockup training are conducted for critical work	Percent of pre-job briefs found unacceptable from quality assurance (QA) field observations
		Just-in-time training is conducted for infrequently performed tasks	
	CONDUCT OF WORK (INCLUDING MAINTENANCE, OPERATIONS, RADIATION PROTECTION, AND ENGINEERING)	Changes that result in margin reductions are communicated to all affected personnel, and the personnel demonstrate that they understand the changes	
	Procedures are available (accessible), up-to-date, accurate, useable, and consider interdepartmental interfaces	Trend in annual number of CRs attributed to inadequate procedures	
	Managers communicate to personnel which procedures require verbatim compliance and such procedures are followed	Trend in annual number of CRs that are associated with personnel not following procedures	
	Procedures that do not require verbatim compliance are used in accordance with plant requirements		
	Procedure changes are made in accordance with plant processes	Trend in backlog of procedure changes	
	Labeling of plant components is up-to-date, accurate, and reflects actual plant configuration		
	Critical areas of the plant are kept clean and orderly		
	Human performance tools (e.g., STAR, self-check, peer-check, contingency plans, post-job review) are provided and used	Trend of human performance error rate	
	Human performance is monitored and periodically assessed, and necessary actions are taken (e.g., communicated) as needed		
		Trend of CRs assessed at the SCAQ level involving human performance	
		Annual number of inspection findings with human performance cross-cutting aspects	
		Annual number of LERs coded for human performance in NRC Human Factors Information System (HFIS) database	

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		Personnel are fit for duty as specified by NRC requirements	Annual number of licensee-identified instances of personnel unfit for duty
		Interfaces are maintained with offsite organizations (e.g., grid operators, emergency preparedness interfaces) such that there are no negative impacts on nuclear station operations	
		There is evidence of interdepartmental communication, coordination, and cooperation at all levels of the organization	
	QUESTIONING ATTITUDE	Staff actions and communications demonstrate a questioning attitude (e.g., staff raises questions during pre-job briefs and shift turnovers, staff asks questions when facing an unforeseen situation)	Percentage of pre-job briefs that generate CRs
	Management actions and communications demonstrate a questioning attitude (e.g., managers challenge actions, discuss consequences of plans, etc. during routine morning meetings)	Annual number of morning meetings that develop contingencies to deal with unplanned possibilities	
	Personnel demonstrate knowledge of contingency actions that have been developed for potential problems and implement them conservatively		
	Personnel offer innovative ideas to solve problems		
	Personnel identify conditions or behaviors that may adversely impact safety		

GLOSSARY OF TERMS

Alternative process (AP): a process to raise concerns that is an alternate to the licensee's corrective action program (CAP) or line management (e.g., the ECP).

Benchmarking: The practice of studying other organizations' products and business practices in order to improve an organization's own performance.

Chilling Effect: An environment in which individuals fear retaliation for engaging in protected activities as defined in NRC's employee protection regulations.

Condition Reports (CR): This term is used generically to refer to any report generated to document a deficient condition. Also called Notifications, Problem Reports, etc.

Critical Activities: Infrequently performed plant operations or change in plant status that results in increased personnel or plant risk (e.g. refueling activities including mid-loop operations, initial plant criticality following a refueling outage, replacement of reactor vessel head, or abnormal plant configurations).

Employee Concerns Program (ECP): A program established as an avenue for personnel to raise nuclear safety issues.

Human Performance: Actions of individuals when using or maintaining the system to meet performance standards, under the conditions in which the system will be used.

Personnel Error: Human behavior (actions or inactions) that deviates from what was planned, desired, or expected in a given task environment.

Human Performance Error Rate: Typically calculated as the number of personnel errors per 10,000 person hours worked.

Management: Individuals above the first-line supervisor level.

Operating Experience (OE): A systematic gathering, analysis, and review of safety significant issues, trends, or recurring events in order to facilitate the timely sharing of this information to affected parties to prevent recurrence.

Oversight Groups: Groups that provide independent assessments of plant activities and performance; may be corporate or industry based.

Personnel: Includes all management, non-management employees, and contractors.

Reportable Events: Licensee Event Reports (LERs) and NRC Notifications

Root Cause: Actions or set of conditions that, if eliminated or modified, would keep the event from recurring as well as prevent similar events from occurring.

Safety Conscious Work Environment (SCWE): A work environment where employees are encouraged to raise safety concerns and where concerns are promptly reviewed, given the proper priority based on their potential safety significance, and appropriately resolved with timely feedback to the originator of the concerns and to other employees.

Self-Assessment: An internal review of an organization's activities or practices conducted internally to assess performance and identify areas for improvement.

Staff: Includes first-line supervisor level and below.

Abbreviations/Acronyms

AP	Alternative Processes
CAP	Corrective Action Program
CAQ	Condition Adverse to Quality
CR	Condition Report
ECP	Employee Concerns Program
FSAR	Final Safety Analysis Report
HIRD	Harassment, Intimidation, Retaliation, Discrimination
OE	Operating Experience
PI&R	Problem Identification and Resolution
SCAQ	Significant Condition Adverse to Quality