

Enclosure 95003.02-D  
Guidance for Structured Behavioral Observations

This enclosure provides guidance for developing and using structured behavioral observation checklists to identify patterns of behavior related to the components of safety culture. This enclosure does not provide behavioral observation checklists for the operating experience and self-assessment safety culture components because they are process-type components and don't lend themselves to behavioral observation.

1. Overview

Behavioral Observation Checklists involve the use of a structured format to record observational data. Key observable attributes of behaviors associated with safety culture are listed in checklist fashion, which ensures structured collection of data associated with observations. The structure also allows quantification of observational information. Behavioral Observation Checklists may also be used to guide and focus observations without quantifying the information collected.

2. Strengths

- Data collected reflect real activities (versus respondent opinions or perceptions).
- Multiple observations of similar activities (e.g., turnovers) allow quantification of information across multiple occurrences of the activity.
- Observer is non-intrusive and does not interrupt activity.
- Checklist format ensures similar information will be collected across multiple observers.
- When quantitative data are not obtained or cannot be reported due to limited observations, qualitative data can be useful.

3. Limitations

- Observer's presence may affect the manner in which the activity is conducted.
- In some cases, multiple observations of a similar activity are not possible.
- Unless multiple observations of a similar activity are conducted, quantitative data cannot be reported.
- Those observed may avoid discussing any sensitive topics in the presence of the observer.

4. Applications

To be completed when observing:

- licensee decision-making processes, including goal-setting, oversight, and work planning sessions;
- the actual performance of work activities, including activities for which formal procedures and standards of behavior exist;

- communications, including interactions between managers and staff, between peers, as well as interdepartmental, intradepartmental and external communications; and
- training.

#### 5. Guidance:

- Identify the categories of activities that will be observed. Select activities to observe based on their relevance to specific safety culture components to be assessed with this data-collection method, as defined in the assessment plan.
- Through discussion with knowledgeable licensee personnel, identify the frequency with which the selected activities typically occur and determine the number of observations to be scheduled for each category of activity. If structured behavioral observation will be the primary method of collecting data about a specific safety culture component (e.g., decision-making), plan to observe a minimum of 25 activities of interest over the course of a one-week inspection. A minimum of 15 observations may be sufficient if behavioral observation will be used as a supplement to other information-gathering methods.
- To develop consistency in using the checklists among different observers,
  - discuss the checklist items in advance and determine how they will be used;
  - jointly observe several of the same activities;
  - compare the results obtained by the different observers when observing the same activity;
  - discuss and resolve any differences in how the checklist items were interpreted;
  - revise the checklist items, as necessary.
- For each category of activity to be observed, select a subset of the checklist items below or develop additional items, based on the nature of the activity and the safety culture components to be assessed. Do not plan to collect data about all of the safety culture components from any one observation, because the behaviors associated with some components do not occur with sufficient frequency to be provide an adequate sample of observations (e.g., budget planning meetings involving corporate and site management that might provide insights related to the Resources component).
- Include no more than 15 items on a single checklist. Longer checklists are difficult to use and searching for items on the checklist can distract the observer.
- Use the same checklist items when observing activities that fall into the same category of activities, so that the frequencies of the behaviors of interest can be determined.
- For activities performed frequently during the inspection (e.g., shift turnover, pre-job briefs, and surveillance and maintenance activities), plan to observe up to 25 of the activities during the inspection.

- For infrequently performed activities (e.g. weekly management/staff meetings, all-hands meetings, personnel action meetings) plan to observe a sample of convenience (i.e., perform the observation if one occurs during the inspection and if safety culture assessors are available at the time.)
- Maintain the checklists used for each observation, even if no data were collected, in order to document the sample size.
- For each checklist created, the safety culture assessor should note:
  - the date and time of the observation;
  - the activity observed (e.g., pre-job briefing, shift turnover, plan-of-the-day meeting, department meetings, a maintenance job, corrective action review meeting);
  - the levels of management and staff involved (e.g., senior management, functional area management, middle management, first-line supervisors, staff or contractors);
  - the functional area(s) involved (e.g., operations, maintenance, radiation protection, engineering);
  - the number of individuals involved, and
  - other characteristics of the activity that can be used to compare and contrast data collected from different activities.
- Provide space on the checklist for the safety culture assessor to add notes that record more details about the interactions observed. For example, one of the checklist items below asks, "Was risk or nuclear safety discussed?" If the answer is yes, the safety culture assessor should add a description of the context in which risk or safety was discussed, the extent of the discussion, and an assessment of it. However, the additional information should be recorded only after the observation is completed, in order to ensure that the safety culture assessor is not distracted from observing.
- Following the observation, the safety culture assessor should also document any qualitative assessment of the interaction or work activity observed, related to the safety culture components. This information will be necessary to ensure that the observation data are appropriately interpreted.
- When all observations have been completed, summarize the following:
  - The number of observations made of each category of activity;
  - The extent to which behaviors were observed that are consistent with the safety culture components;
  - The extent to which behaviors were observed that are inconsistent with the safety culture components; and
  - Any qualitative information necessary to interpret properly the quantitative data.

This information can then be used to assess how the components of safety culture are integrated into day-to-day activities. This information is useful in assessing the overall safety culture as well as the safety culture of individual functional groups.

Example checklist items:

### Accountability

*(Observed during ongoing work activities.)*

Are the personnel who are performing the activities given specific success criteria that define organizational expectations before beginning the work? Yes \_\_\_ No \_\_\_ N/A\_\_\_

If yes, nuclear safety was \_\_\_was not \_\_\_ among the expectations.

Is performance feedback timely, so that corrections in performance can be achieved? Yes \_\_\_ No \_\_\_ N/A\_\_\_

If yes, did any feedback concern nuclear safety? Yes \_\_\_ No \_\_\_ N/A\_\_\_

Is performance feedback available from verbal communication \_\_\_ or performance evaluation reports generated at a later date \_\_\_?

If yes, did any feedback concern nuclear safety? Yes \_\_\_ No \_\_\_ N/A\_\_\_

Did any supervisor offer performance feedback related to nuclear safety? Yes \_\_\_ No \_\_\_ N/A\_\_\_

Did any manager offer performance feedback related to nuclear safety? Yes \_\_\_ No \_\_\_ N/A\_\_\_

Did any peers offer performance feedback related to nuclear safety? Yes \_\_\_ No \_\_\_ N/A\_\_\_

If it was necessary to deviate from the originally planned activities, did the personnel performing the activities have the authority to approve the deviation? Yes \_\_\_ No \_\_\_ N/A\_\_\_

If yes, did the deviation have nuclear safety implications? Yes \_\_\_ No \_\_\_ N/A\_\_\_

If the work is being performed by a crew, is there an obvious structure to the group (i.e., there is a clearly identified group leader and specified roles and responsibilities for each of the other group members)? Yes \_\_\_ No \_\_\_ N/A\_\_\_

Were the personnel selected to perform the activities familiar with the task requirements or was there obvious uncertainty regarding the tasks to be performed \_\_\_?

*(To be observed during meetings.)*

Were the specific individuals responsible for implementing the initiative, project, or program under discussion present? Yes \_\_\_ No \_\_\_ N/A\_\_\_

Was the individual given an opportunity to present discuss or defend his or her position? Yes \_\_\_ No \_\_\_ N/A\_\_\_

If the responsible individual was present, did s/he receive any feedback related to nuclear safety? Yes \_\_\_ No \_\_\_ N/A \_\_\_

If yes, was the feedback provided by (check all that apply):

- Peers
- Supervisor
- Manager

If the responsible individual was present, did s/he receive any feedback related to deadlines, costs, quality or other performance criteria? Yes \_\_\_ No \_\_\_ N/A \_\_\_

If yes, was the feedback provided by (check all that apply):

- Peers
- Supervisor
- Manager

Corrective action program (CAP)

*(Typically observed during issue screening, management screening, or closure meetings)*

Which of the following individuals participated in the meeting?

- Corporate management \_\_\_
- Senior management \_\_\_
- Functional area management \_\_\_
- Middle management \_\_\_
- Licensee staff \_\_\_
- Contractor \_\_\_
- Other (describe)? \_\_\_

Were screening criteria used? Yes \_\_\_ No \_\_\_ N/A \_\_\_

Were the screening criteria conservatively applied for every issue?

- Yes \_\_\_ No \_\_\_ N/A \_\_\_

Did anyone challenge how any of the criteria were being applied?

- Yes \_\_\_ No \_\_\_ N/A \_\_\_

Did anyone challenge the prioritization of any issues?

- Yes \_\_\_ No \_\_\_ N/A \_\_\_

Were any issues upgraded or downgraded in priority? Yes \_\_\_ No \_\_\_ N/A \_\_\_

Upgraded \_\_\_ Downgraded \_\_\_

If so, did anyone challenge the change?

- Yes \_\_\_ No \_\_\_ N/A \_\_\_

Were issues thoroughly discussed? Yes \_\_\_ No \_\_\_ N/A \_\_\_

Was safety, as applicable, considered for every issue? Yes \_\_\_ No \_\_\_ N/A \_\_\_

Were there any issues where it was decided not enough information was available to make the prioritization? Yes \_\_\_ No \_\_\_ N/A \_\_\_

If so, were any individuals directly involved with the issue consulted or plans made to consult the individuals involved? Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

Did the reviewers have an understanding of the evaluation (i.e., they reviewed the evaluation prior to the meeting)? Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

Did the reviewers place safety as the highest priority? Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

Was there any discussion about the scope of the evaluation (i.e., what areas the evaluation covered)? Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

What about depth (i.e., how thorough/in-depth the issue was investigated)?  
Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

Did any reviewer raise any concerns about problems not being adequately investigated in the evaluation?

Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

Was there any discussion on if the corrective action(s) presented could resolve all the problems identified in the evaluation?

Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

Did any reviewer interact with the evaluator(s) of the issue? Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

If so, did the reviewer(s) behave at any point in a way that could potentially discourage the evaluator from performing a thorough/in-depth investigation in the future?

Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

Were there any evaluations not accepted by the reviewers? Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

Is yes, was resolution on what to do about the evaluation reached?

Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

If yes, was it through consensus-seeking \_\_\_\_ or top-down direction from management \_\_\_\_?

If no, was it decided to push the decision up the management hierarchy \_\_\_\_ or not \_\_\_\_?

If it was determined that the evaluation should have any rework done:

Was guidance provided on how to improve the evaluation?

Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

Were any additional resources (e.g., training, additional evaluators, management assistance) offered to the evaluator(s)?

Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

Were there any concerns raised about the new deadline?

Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

If yes, who raised the concern? Reviewer(s) \_\_\_\_ Evaluator(s) \_\_\_\_

## Continuous Learning Environment

*(When observing training.)*

Is the training a result of an event or incident that occurred at the facility due to a human performance problem? Yes \_\_\_ No \_\_\_ N/A \_\_\_

Do trainees appear hesitant to ask questions or seek clarification?  
Yes \_\_\_ No \_\_\_ N/A \_\_\_

Do trainees appear to be engaged? Yes \_\_\_ No \_\_\_ N/A \_\_\_

Do trainees have an opportunity to offer feedback about the training?  
Yes \_\_\_ No \_\_\_ N/A \_\_\_

Are trainees evaluated at the completion of training?  
Yes \_\_\_ No \_\_\_ N/A \_\_\_

Are trainees provided with feedback while the training is ongoing?  
Yes \_\_\_ No \_\_\_ N/A \_\_\_

Are lessons learned from internal or external operating experience incorporated into the training? Yes \_\_\_ No \_\_\_ N/A \_\_\_

Is nuclear safety addressed during the training? Yes \_\_\_ No \_\_\_ N/A \_\_\_

## Decision-making (and Organizational Change Management, as applicable)

*(May be observed in scheduled or informal meetings or during ongoing work activities.)*

Did the decision involve technical \_\_\_\_, policy \_\_\_\_, or personnel \_\_ issues?

Were any uncertainties discussed? Yes \_\_\_ No \_\_\_ N/A \_\_\_

Were alternatives generated \_\_\_ or not \_\_\_?

Was "risk" or nuclear safety discussed? Yes \_\_\_ No \_\_\_ N/A \_\_\_

Were conservative assumptions used? Yes \_\_\_ No \_\_\_ N/A \_\_\_

Were any alternatives rejected because of risk or nuclear safety considerations?  
Yes \_\_\_ No \_\_\_ N/A \_\_\_

Was resolution reached \_\_\_ or not \_\_\_?

If resolution was reached, was it through consensus-seeking \_\_\_ or top-down direction from management \_\_\_?

If resolution was not reached, was it decided to push the decision up the management hierarchy \_\_\_ or not \_\_\_?

If resolution was not reached, was it decided to seek more information \_\_\_ or not \_\_\_?

If nuclear safety was involved, was the decision based on sufficient evidence that it was safe to proceed? Yes \_\_\_ No \_\_\_ N/A \_\_\_

If nuclear safety was involved, was the decision based on sufficient evidence that it was unsafe to proceed? Yes \_\_\_ No \_\_\_ N/A \_\_\_

If the decision concerned policies, rules, and goals, did the manager consult with his/her immediate subordinates? Yes \_\_\_ No \_\_\_ N/A \_\_\_

If the decision concerned staffing, did the manager consult with his/her immediate subordinates? Yes \_\_\_ No \_\_\_ N/A \_\_\_

If the decision concerned a technical issue, did the manager consult with any technical staff? Yes \_\_\_ No \_\_\_ N/A \_\_\_

If the decision concerned how to solve a work-related problem, did the individual consult his/her superior? Yes \_\_\_ No \_\_\_ N/A \_\_\_

Was a plan made for communicating the results of the decision? Yes \_\_\_ No \_\_\_ N/A \_\_\_

If yes, was communicating with the affected individuals discussed?  
Yes \_\_\_ No \_\_\_ N/A \_\_\_

If yes, was communicating with a higher management level discussed?  
Yes \_\_\_ No \_\_\_ N/A \_\_\_

Were any previous, similar decisions discussed? Yes \_\_\_ No \_\_\_ N/A \_\_\_

If yes, was the effectiveness of the previous decision discussed?  
Yes \_\_\_ No \_\_\_ N/A \_\_\_

### Environment for Raising Concerns

*(Observed during any interactions among site personnel.)*

Did a subordinate(s) ask any questions of a superior during the interaction?  
Yes \_\_\_ No \_\_\_ N/A \_\_\_

If yes, did the superior answer the question(s)? Yes \_\_\_ No \_\_\_ N/A \_\_\_

Did a subordinate(s) raise any concerns to a superior during the interaction?  
Yes \_\_\_ No \_\_\_ N/A \_\_\_

If yes, did the concerns involve (check all that apply):  
\_\_\_ nuclear safety  
\_\_\_ radiological or industrial safety  
\_\_\_ resources (e.g., staff, expertise)  
\_\_\_ scheduling or deadlines  
\_\_\_ other

If yes, did the superior address the concerns? Yes \_\_\_ No \_\_\_ N/A \_\_\_

If yes, did the superior resolve the concerns? Yes \_\_\_ No \_\_\_ N/A \_\_\_

If yes, was the supervisor's response open and non-defensive?  
Yes \_\_\_ No \_\_\_ N/A \_\_\_

Did a subordinate offer any suggestions to a superior during the interaction?  
Yes \_\_\_ No \_\_\_ N/A \_\_\_



If yes, did the superior discuss the suggestion(s)? Yes \_\_\_ No \_\_\_ N/A\_\_\_

Was the interaction obviously strained \_\_\_\_, obviously pleasant \_\_\_\_, or was there no apparent affect \_\_\_?

Was the interaction related to a safety issue \_\_\_\_, regulatory requirement(s) \_\_\_\_, production issue(s) \_\_\_\_, personal conflict \_\_\_\_, other \_\_\_?

Did the interaction include discussion of ways to improve the facility performance?  
Yes \_\_\_ No \_\_\_ N/A\_\_\_

Did the interaction include discussion of ways to improve personnel performance?  
Yes \_\_\_ No \_\_\_ N/A\_\_\_

Did any staff member self-report an error? Yes \_\_\_ No \_\_\_ N/A\_\_\_

If yes, did peers react favorably? Yes \_\_\_ No \_\_\_ N/A\_\_\_

If yes, did supervisor(s) react favorably? Yes \_\_\_ No \_\_\_ N/A\_\_\_

### Preventing and Detecting Retaliation

*(Observed during management or oversight meetings.)*

Was there a rigorous investigation of the potential issue? Yes \_\_\_ No \_\_\_ N/A\_\_\_

Did the disposition seem appropriate? Yes \_\_\_ No \_\_\_ N/A\_\_\_

Was the potential for the action to discourage the reporting of concerns discussed?  
Yes \_\_\_ No \_\_\_ N/A\_\_\_

If yes, mitigation actions were \_\_\_ were not \_\_\_ assigned.

### Resources

*(Observed during ongoing work activities. See also procedures-related items in Work Practices.)*

Did personnel have problems reading the work package (legibility)?  
Yes \_\_\_ No \_\_\_ N/A\_\_\_

Did personnel have problems interpreting the information in the work package?  
Yes \_\_\_ No \_\_\_ N/A\_\_\_

Was any information missing from the work package? Yes \_\_\_ No \_\_\_ N/A\_\_\_

Were an adequate number of staff available to perform the work?  
Yes \_\_\_ No \_\_\_ N/A\_\_\_

Were the procedures adequate to perform the work? Yes \_\_\_ No \_\_\_ N/A\_\_\_

Did personnel have the equipment necessary to perform the work safely?  
Yes \_\_\_ No \_\_\_ N/A\_\_\_

## Safety Policies

*(Typically observed in scheduled meetings.)*

Was nuclear safety discussed as a goal? Yes \_\_\_ No \_\_\_ N/A\_\_\_

Were goals other than nuclear safety discussed? Yes \_\_\_ No \_\_\_ N/A\_\_\_

Goals were \_\_\_ were not \_\_\_ prioritized?

Nuclear safety was \_\_\_ was not\_\_\_ assigned the highest priority.

Were any target levels attached to the goals? Yes \_\_\_ No \_\_\_ N/A\_\_\_

If goals were being set on a departmental level, were overall organizational goals factored in? Yes \_\_\_ No \_\_\_ N/A\_\_\_

If yes, nuclear safety was \_\_\_ was not \_\_\_ one of the goals.

If goals were being set on an organizational level, were corporate goals factored in?  
Yes \_\_\_ No \_\_\_ N/A\_\_\_

If yes, nuclear safety was \_\_\_ was not \_\_\_ one of the goals.

Was there overall agreement among the individuals setting the goals on what the goals and priorities should be? Yes \_\_\_ No\_\_\_ N/A\_\_\_

Was there any indication that the goals of different departments were in conflict?  
Yes \_\_\_ No \_\_\_ N/A\_\_\_

If nuclear safety goals were discussed, the following individuals brought them up:

- \_\_\_ Corporate management
- \_\_\_ Senior management
- \_\_\_ Functional area management
- \_\_\_ Middle management
- \_\_\_ Licensee staff
- \_\_\_ Contractor
- \_\_\_ Other (describe)

If production goals were discussed, was the potential impact on nuclear safety mentioned?

Yes \_\_\_ No \_\_\_ N/A\_\_\_

## Work Control

*(Observed during ongoing work activities or a work planning session.)*

When planning a work activity, were the following issues discussed (check all that apply)?

- \_\_\_ risk insights
- \_\_\_ defense in depth
- \_\_\_ job site conditions that could impact human performance
- \_\_\_ task sequencing to optimize system availability
- \_\_\_ potential impacts on nuclear safety of performing the activity at the same time as other activities are performed

- contingencies
- compensatory actions
- conditions under which the work would need to stop for nuclear safety reasons
- the impact on nuclear safety of any temporary modifications to be installed
- the impact on human performance of any operator work-arounds to be created
- any relevant internal or external operating experience

A pre-job briefing was  was not  conducted. If it was conducted, were the following issues discussed (check all that apply)?

- risk insights and/or nuclear safety considerations
- defense in depth
- job site conditions that could impact human performance and means to mitigate their potential effects
- contingencies for mitigating the effects of mistakes and/or possible worst-case scenarios
- procedure usage requirements
- other work activities that have the potential to interact with this one
- conditions under which work would be stopped for safety reasons
- communications requirements
- applicable lessons learned from internal or external operating experience

When performing a work activity simultaneously with other work activities that had the potential to interact, communications were  were not  maintained between the individuals/groups performing the different activities.

When performing the work activity, unexpected conditions did  did not  arise.

### Work Practices

*(Observed during ongoing work activities.)*

Are there obvious time pressures for work completion? Yes  No  N/A

If obvious time pressures exist:

Do they appear reasonable given the activities to be performed?

Yes  No  N/A

Is there evidence that those pressures compromised the quality of the work performed in any way? Yes  No  N/A

Is there evidence that those pressures compromised the safety of the work performed in any way? Yes  No  N/A

Were time constraints for the work activities clearly communicated to all individuals involved in the activity? Yes  No  N/A

The reason for the time constraints is related to (check all that apply):

- nuclear safety concerns
- limited personnel resources
- other scheduled work activities
- pressure to get the facility back on-line
- other/unknown

Human error prevention techniques were  were not  used.

Human error prevention techniques were \_\_\_ were not \_\_\_ discussed during the pre-job brief.

Were procedures used in performing the activity? Yes \_\_\_ No \_\_\_ N/A\_\_\_

If procedures were used, were they conveniently located and easily accessible?  
Yes \_\_\_ No \_\_\_ N/A\_\_\_

Verbatim compliance with the procedures was \_\_\_ was not \_\_\_ required.

If verbatim compliance was required, was it achieved? Yes \_\_\_ No \_\_\_ N/A\_\_\_  
If verbatim compliance was not achieved,  
(Note - these items relate to Resources.)

was it because the activities described by the procedure could not be performed as written, given the conditions (e.g., time constraints, personnel resources, unexpected conditions)? Yes \_\_\_ No \_\_\_ N/A\_\_\_

was it because the procedures not well understood or understandable?  
Yes \_\_\_ No \_\_\_ N/A \_\_\_

The formal process for deviating from a procedure was \_\_\_ was not \_\_\_ followed.

Were any problems encountered during performance of the work activities?  
Yes \_\_\_ No \_\_\_ N/A\_\_\_

If yes, did the problems have any nuclear safety implications?  
Yes \_\_\_ No \_\_\_ N/A\_\_\_

Work was \_\_\_ was not \_\_\_ stopped until the problem was resolved.

If a management decision or additional expertise was required to solve the problem, were the necessary individuals made available within a reasonable time period?  
Yes \_\_\_ No \_\_\_ N/A\_\_\_

Did any personnel point out *conditions* that could adversely impact nuclear safety?  
Yes \_\_\_ No \_\_\_ N/A\_\_\_

Did any personnel point out *behaviors* that could adversely impact nuclear safety?  
Yes \_\_\_ No \_\_\_ N/A\_\_\_

Were any work-arounds used? Yes \_\_\_ No \_\_\_ N/A\_\_\_

If yes, was the work-around long-standing \_\_\_ or created for the current work activity \_\_\_?

Was it proceduralized? Yes \_\_\_ No \_\_\_ N/A\_\_\_

If the work activity was considered critical, was management present?  
Yes \_\_\_ No \_\_\_ N/A\_\_\_

If yes, did management offer direction \_\_\_ or feedback \_\_\_ ?

Was the direction or feedback related to nuclear safety? Yes \_\_\_ No \_\_\_ N/A\_\_\_

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