

Patient Safety Tip of the Week

September 23, 2025

Great Article on Normalization of Deviance in the OR

We’ve discussed “**normalization of deviance**” in several of our columns. This is where the culture of the system has led to acceptance of a certain deviation from proper practice as being “normal” and allowed that deviation to be performed by many individuals. The deviation has been used so frequently without serious adverse consequences occurring that staff no longer consider it abnormal. The Challenger disaster, in particular, brought to light the importance of concepts like “**normalization of deviance**” where successes despite problems led to the acceptance of such problems as “normal” and therefore tolerable.

Normalization of deviance is also something we see in our everyday lives. Just look at traffic on any highway. Everyone likes to travel at a speed which is a few miles per hour above the speed limit. We are all guilty! We may try to go at a speed where we are not likely to get a traffic ticket. But maybe at that speed we won’t be able to avoid that collision with a deer.

We’ve been giving a course on why accidents happen for several years at Dartmouth’s Osher adult learning program. We’ve seen normalization of deviance as a contributory factor in aviation accidents, maritime accidents, automotive accidents, and many industrial accidents, in addition to healthcare incidents.

In our November 21, 2023 Patient Safety Tip of the Week “[Another Terrifying MRI Accident](#)” we discussed an accident in which a nurse was crushed by a hospital bed that was sucked into an MRI unit. The metal detection system failed to alert that individual and staff. But the staff had ignored manufacturer recommendations to perform daily qualitative checks and weekly/monthly checks to ensure the metal detection was working appropriately on such units.

In our April 12, 2022 Patient Safety Tip of the Week “[A Healthcare Worker’s Worst Fear](#)” we discussed the fatal administration of a neuromuscular blocking agent to a patient. One of the contributory factors was overriding an alert when a medication was

pulled from an automated dispensing cabinet. We noted that the CMS investigation did not mention whether overriding an ADC alert was an issue unique to the involved nurse or whether ADC overrides had become a routine part of the culture of the unit (i.e. “**normalization of deviance**”).

In our September 6, 2022 Patient Safety Tip of the Week “[AORN and Others on Retained Surgical Items](#)” it was mentioned how “**normalization of deviance**” often slips into organizations and can be a factor contributing to RSI’s (retained surgical items). Because counting is a routine, it gets pushed down the priority list by busy clinicians. It becomes easier for them to cut corners and, when nothing happens (RSI’s are not common occurrences), there is no motivation to return to the “correct” way. Thus, the deviation from the desired standard becomes “normalized” as a new, unofficial standard.

All too often, when we are doing a root cause analysis (RCA) or other incident investigation or reading about an incident or accident in any industry, we see a contributory factor where an individual “did something wrong”. One of the first questions we ask then is “Were other individuals also doing that same thing?”. That individual often gets blamed for the behavior because an adverse event occurred, whereas all the others had been doing the same thing but had not been involved in an incident with an adverse outcome.

Wilbanks and Gardenier ([Wilbanks 2025](#)) just published a systematic review of normalization of deviance in the perioperative setting. They point out that normalization of deviance is a major contributing factor to medical errors that impair patient safety in perioperative settings, and that normalization of deviance is strongly influenced by the **culture of patient safety** in a health care setting. They also note that **production pressure** is a major contributor to the occurrence of normalization of deviance and some have even used the two terms synonymously.

Wilbanks and Gardenier note **desensitization and drift** as a theme often found in their literature review. They note that we often develop new policies and procedures in response to a specific adverse patient care event. But, over time, these new policies and procedures are ignored as actual clinical practices drift away from their original state because no other similar patient issues occur. They stress that changes in policy and procedures secondary to an adverse patient care event must be actively monitored over time to prevent desensitization and drift. We often see this in failure to adhere strictly to surgical timeouts or surgical counts because “we haven’t had a problem”.

Another major theme in the literature is the impact of **production pressure** and **workload** issues. Cutting corners to meet production goals often leads to acceptance of deviations. Similarly, during periods of excessive workload, clinicians may skip steps they consider to be of little importance, and over time those behaviors become ingrained.

Their article also has sidebars that you need to download from the supplementary materials:

- Specific Examples of Normalization of Deviance Reported in the Literature

- Contributing Factors to the Occurrence of Normalization of Deviance
- Considerations for Preventing and Reducing Normalization of Deviance

The review does include some specific examples of normalization of deviance reported in the literature, like inappropriately bypassing safety features of barcode medication administration or other technology, allowing physicians to bypass policies and procedures because they generate revenue for hospital, turning off audible alarms for hemodynamic monitoring devices because they 'make too much noise'.

We'll bet you can provide much better examples of normalization of deviance in your own organizations. How often is there inadequate drying time after surgical prep for a head and neck procedure because the surgeon is in a hurry to get started? How often is a timeout skipped prior to a bedside procedure? How often are required double checks performed in a perfunctory manner? And we all know that adherence to hand hygiene recommendations is poor, particularly by physicians.

Wilbanks and Gardenier note that it is difficult to monitor and identify normalization of deviance. They note that identification often requires an individual directly observing the behavior of a clinician in real time and intentionally searching for its existence, noting that the individuals directly involved in the aberrant behavior will very likely not recognize their behavior as inappropriate. In fact, many clinicians may not believe that their behaviors are inappropriate even when confronted.

Wilbanks and Gardenier emphasize that the most important element in preventing normalization of deviance is having a good **culture of patient safety**. Having an open, nonpunitive culture where all are encouraged to speak up without fear of retribution is critical. "Improving communication and interdisciplinary team dynamics is one approach that can have an integral role in mitigating the occurrence of normalization of deviance and improving patient safety." Programs like TeamSTEPPS™ and crew resource management are valuable at improving communication and fostering a good culture of patient safety. When you do change policies or procedures in response to an adverse event, it is critical to get buy-in from all parties, so they understand the rationale for the changes, but you also need to follow up and monitor that behaviors don't revert over time.

Similar to when we identify "workarounds", when we identify "normalization of deviance" it is not appropriate to just tell people to "stop doing it". We should always look to see what is the underlying cause of that behavior and seek to remedy that underlying cause.

The article by Wilbanks and Gardenier is a reminder that we often fall into complacency and normalize behaviors that may seem safe but may eventually lead to a serious event that could have been avoided.

References:

Wilbanks BA, Gardenier C. Normalization of Deviance in the Perioperative Setting: A Systematic Literature Review. AORN J 2025; 122(3): 163-172
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