Novice to Expert
Through the Stages to
Success in Nursing
CE556 :: 1.00 Hours

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Objectives

The goal of this program is to provide nurses with a framework they can use to coach nurses through the five stages that comprise novice to expert. After studying the information presented here, you will be able to —

- Describe Patricia Benner’s five stages of moving from novice to expert.
- Discuss why it’s important to assist nurses on their journey from novice to expert.
- Explain how nurses can help one another in navigating the five stages.

Florence Nightingale understood the importance of nursing competence long before it became a favorite topic of conversation in our profession. Her passion for excellence in nursing shines through in the letters she wrote. For example, several letters from 1861 refer to the need to provide training and to attract qualified candidates. However, Nightingale also knew that completing a basic nursing education didn’t guarantee competency years later and even recommended nurses receive certificates for recent experience, a concept analogous to today’s continuing education.

As our profession evolves, competency in a rapidly changing healthcare environment remains a key component of excellent nursing care. Competency gives us confidence to care for our patients. But developing competency is but one step to becoming an expert nurse. Nurses’ expertise grows over the years — a product of experiences. We must support one another as we develop our expertise.

A well thought-out orientation program is the key to getting off to a good start. Consider the case of Emily Levine.* Emily, an excited new grad, reports to duty at her dream job: a staff nurse in the ICU in a large metropolitan hospital. Full of hope, confident the hospital is the right fit, Emily meets Kelly, her preceptor, who has worked in the ICU for seven years, and the other team members.

Kelly helps Emily identify her learning needs and provides frequent, positive feedback. Kelly assigns Emily to care for patients with similar conditions so she can improve her clinical reasoning ability. Kelly helps Emily identify priorities and points out complications that may occur in her patients. Emily attends a support group of new grad nurses at the hospital to discuss her experiences.

After orientation ends, Emily is surrounded by nurses who mentor and nurture her growth as a
professional, competent nurse. She benefits from attending ongoing support group meetings. By the end of a year, Emily is happy in her position and well on her way to becoming a clinically competent nurse.

But not all nurses have an experience like Emily’s. Consider the following facts:

- A study reported that 13% of newly licensed RNs changed jobs after one year, and 37% intended to search for a new position in one year.\(^3\)
- Another study found that the average voluntary turnover for first-year nurses was 27.1%; for nurses with one to three years of service, 28.1%.\(^4\)

Frequently cited reasons for leaving jobs include workplace stress and a lack of peer support. The nurses left behind must then begin again with new nurses, creating more stress in the already stressful hospital environment, while coping with their own needs. One way to encourage retention is for nurses to support each other in their roles. Doing so benefits both nurses (by reducing the stress of turnover) and patients (who benefit from more experienced nursing care). One of the most useful frameworks for addressing nurses’ needs at various stages of professional growth is the model of the stages of clinical competence first described by Patricia Benner, RN, PhD, FAAN, in her classic book, *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, published in 1984, with a commemorative edition in 2001.\(^5\) Benner, along with co-authors Christine Tanner, RN, PhD, FAAN, and Catherine Chesla, RN, DNSc, FAAN, expanded on these themes in the second edition of their book *Expertise in Nursing Practice: Caring, Clinical Judgment, and Ethics*, published in 2009.\(^6\) The Benner model can help nurses understand how expertise develops, allowing them to support and nurture each other.

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**Benner’s Stages of Clinical Competence**

**Stage 1: Novice.**

Beginners have no experience with the situations in which they are expected to perform. They learn context-free rules to apply universally. For example, “Check the blood pressure every hour. If the diastolic over 100 mmHg, call the physician.” But rules can’t tell a novice which tasks to perform in each actual situation, so behavior in the clinical setting is limited and inflexible.

**Stage 2: Advanced beginner.**

Nurses have had enough experience to note recurring, meaningful components of a situation. The advanced beginner begins to formulate guidelines that dictate actions. They are new grads in their first job. They have “knowledge, skills, and know how, but don’t have many in-depth encounters with a similar patient population,” Benner says.

**Stage 3: Competent.**

These nurses begin to see their actions in terms of long-range goals or plans. Competent nurses lack the speed and flexibility of proficient nurses, but have a feeling of mastery and can rely on advanced planning and organizational skills. An increasing sense of saliency helps them recognize what is important. They begin to recognize patterns and the nature of a clinical situation more quickly and accurately. They need to examine fewer options to make decisions.

**Stage 4: Proficient.**

The nurse views situations as “wholes” rather than parts, and maxims, reflecting nuances of a situation, guide performance. The proficient nurse learns from experience what events typically occur and how to modify plans in response to different events. The nurse sees goals and salient facts, but still must consciously make decisions.

**Stage 5: Expert.**

Experts know what needs to be done thanks to a well-developed ability to recognize demands and resources in situations and attain goals. They no longer rely solely on a rule, guideline, or maxim to
connect understanding of a situation to the appropriate action. They have an intuitive grasp of each situation based on their deep knowledge and experience. They focus on the most relevant problems, not irrelevant alternative options. They use analytical tools only when they have no experience with an event or when events and behaviors don’t occur as expected. The expert often “just knows” a particular situation without internal analysis.

For an idea of the range, consider this example from Benner: Beginning nurses focus on tasks, such as checking vital signs; they basically have a “to do” list. Experts focus on the whole picture even when completing tasks. For example, they note subtle changes, such as a patient’s being a bit harder to arouse than in previous encounters.

**Novice to Expert**

Benner’s model is predicated on the Dreyfus Model of Skill Acquisition. Hubert and Stuart Dreyfus developed their model based on their study of chess players, air force pilots, and army commanders and tank drivers. They contend that expertise is based on experiential (learning through reflection on experiences) and situated (situation-based) learning, which is a function of the activity and context of actual situations and is essential for progressing from a novice to an expert in any field. Benner found parallels in nursing, where improved practice depends on both science and experience. She writes, “At the heart of good clinical judgment and clinical wisdom lies experiential learning from particular cases.” Developing those skills is a long, developmental process.

Benner and her colleagues say that at the same time nurses are engaged in various situations, learning from them, they develop “skills of involvement” with patients and families. Benner and her colleague define skills of involvement as “knowing how close or distant to be with patients and families in critical times of threat and recovery.” These skills are essential for nurses to manage the stress that comes with their careers. Faced with an emotionally challenging patient, an overprotective parent, or a relative who disagrees with a loved one’s end-of-life decision making, nurses must know how to handle the situation to meet the person’s needs while not losing themselves in the process.

Completing the rite of passage from novice to expert isn’t a forgone conclusion. In a March 2009 telephone interview, Benner said a nurse can gain knowledge and skills (“knowing how”) without ever learning the theory (“knowing that”), which brings expertise. Benner’s model has been described as “a seminal qualitative research which lays the foundation for understanding nursing expertise and skill acquisition.”

As nurses develop expertise, particular changes in performance occur, including movement from abstract to concrete, from viewing a situation in bits to viewing it as a whole, and from detached observation to involved performer. It is these changes that underlie nurses’ clinical practice experiences. These cumulative experiences help nurses move through the five stages described in the sidebar, Benner’s stages of clinical competence. Below is a closer look at some stage-based strategies for helping nurses.

Remember that nurses who change practice areas may revert to earlier stages of expertise. For example, an expert nurse in the CCU would not be able to immediately function as an expert in the OR although certainly the nurse’s expertise is valuable. Understanding this helps the nurse deal with the anxiety and uncertainty associated with making the change.

**Novices**

In the second edition of *Expertise in Nursing Practice*, Benner and her coauthors clarify the term “novice,” writing that it “typically occurs in the first year of the nursing student’s clinical education...
one can get through nursing school and take the NCLEX-RN while remaining a novice!”

A student in the clinical setting functions at a basic level and so needs significant oversight and specific directions.

**Advanced Beginners**

Advanced beginners, typically new graduates, are beginning to intuitively observe elements of situations. They rely on setting priorities, but can be overwhelmed when they perceive goals to be equally important. They can’t yet see the bigger picture. Nurses at this stage need experience so they can recognize aspects, such as signs and symptoms, that they may have only studied in the classroom. Nurses at other levels of clinical competence must understand that novices will never get enough experience-based knowledge in school. “They couldn’t be in school long enough to do that,” Benner says. “They develop that knowledge on the job.”

That’s why Benner and her colleagues recommend a new-grad residency program of at least one year. The program should include coursework, mentoring, and use of clinical narratives to help nurses reflect on, and learn from, their experiences. A clinical narrative is a first-person “story,” written by a clinician, that describes a clinical situation, for example, how a nurse managed a patient with signs and symptoms of heart failure. Narratives help clinicians analyze a situation or reflect on their clinical practice and share their experiences with others.

It’s best to first limit advanced beginners to working with patients with a narrow range of conditions so they can more easily develop their competencies. Frequent clinical rotation, part of some residency programs, isn’t recommended since it makes it difficult for nurses to hone their ability to recognize patterns with a similar patient population. With frequent clinical rotation, nurses are less likely to develop in-depth clinical knowledge of a specific population. Rather, they focus on managing the “newness” of the various units.

For advanced beginners, Benner recommends that preceptors forecast what can be expected because these nurses haven’t experienced enough patient trajectories to project into the future. A preceptor might say, “With this complex leg fracture injury, I would be looking for compartment syndrome as a possible complication.”

Advanced beginners also need help in articulating knowledge. “If you go into a room, and the new grad looks overwhelmed, don’t ask, ‘What can I do for you?’” Benner says. “They will be too overloaded to stop and articulate what they need. Instead, just pitch in and help until the crisis passes.” Once it does, you can help the nurse identify what was important and not important in the situation. As one might expect, advanced beginners need help in setting priorities. For example, a preceptor may tell the new nurse that they are going to focus on airway patency and ABG results because the patient is having respiratory distress.

Feedback is important for any new nurse but particularly for new grads, who are used to frequent feedback in school. Positive feedback, such as “You did a great job in getting Mrs. Jones to open up about what was bothering her,” builds confidence. Constructive criticism is also important. For example, “I noticed this patient assignment wasn’t easy for you. Can you think of some reasons why? Then we can talk about what I can do to help you.”

**Competent RNs**

An advanced beginner typically becomes a competent nurse after working in the same situation or
similar ones for two or three years. Benner says this stage can be “a bit of a crisis” as nurses confront the limits of deliberative analysis and planning. Managers should be patient so these nurses can begin to further develop their sense of salience. (With salience, some things stand out as more or less important without deliberately “setting priorities.”) When competent nurses are able to recognize the nature of a situation and incorporate anticipatory planning into the organization process, they are in the position to make the leap to proficiency, the next stage.

Competent nurses may ride an “emotional roller coaster,” reveling in the joy when their decision turns out well and falling into distress when their decision is wrong as they feel great responsibility for their actions. In addition, competent nurses become less detached and more emotionally involved with situations. Although this involvement spurs development to the next stage, it also creates stress.

Helping competent nurses understand this stage helps ease their frustration as they come to understand the limits of planning and prediction. One option is to create a support group for nurses at this level and use first-person clinical narratives to facilitate discussion. Meetings should occur at least every six months during the second and third year of practice. These nurses also benefit from working with proficient nurses. “If you can retain nurses at the end of the competency level, you likely will retain them for a number of years,” Benner says.

**Proficient Nurses**

Proficient nurses can better recognize the salient points of a situation, and decision making becomes more attuned. Benner says this situational recognition is a “real breakthrough.” Proficient nurses can see a current situation in terms of a past situation; this, along with the ability to see changing relevance, brings nurses to a higher level of perception. Nurses are also more involved with patients and families, task performance becomes smoother and quicker, and confidence is enhanced. The enhanced involvement requires nurses to learn how not to over-identify or under-identify with patients and families. Other nurses can help them with this process, and support groups may help.

Proficient nurses can now better identify patient responses and “teachable moments” and are more ready for education related to response-based actions, such as how to manage fluid shifts and titrate vasopressors. In addition, pairing proficient nurses with expert nurses will help retain them. Benner adds that once nurses are firmly in the proficient stage, they will likely become an expert unless they become disengaged.

**Experts**

Expert nurses have a solid technical foundation and the critical-thinking skills to adapt to the unique condition of each patient. Expert nurses intuitively see links between the salient issues in a situation and the appropriate responses to those issues. They have also fine-tuned their emotional responses to patients and families and grasp the relationship between past, present, and future of a situation. Other nurses seek out expert nurses to help problem solve or point out key aspects of a situation.

The abilities of expert nurses make them a valuable resource for other nurses and the organization. However, Benner notes that expert nurses know much more than they can “tell.” For example, they can’t always articulate their knowledge well enough for a new nurse to understand. Having expert nurses write narratives can help raise their consciousness about their knowledge. By observing and working alongside expert nurses, other nurses can uncover even more skilled know-how.

**Spreading the Word**
Benner's model has been used for staff and professional development. For example, a team of pediatric nurses applied the model to subspecialty education. They developed a competency-based education series related to nephrology to meet the needs of the novice to expert pediatric staff nurses. The series consists of three eight-hour courses, annual revalidation sessions, and opportunities for advanced learning and skills acquisition through collaboration with other hospital departments. Expert-level staff nurses, in collaboration with advanced practice nurses, coordinate and teach the series. The team suggests using this model in other specialties and practice settings.

Benner’s concepts have also been applied to advanced practice nurses with the creation of a self-evaluation tool, “APN Novice to Expert Paper.” The authors developed guidelines for APN role self-assessment based on Benner’s five stages. The guidelines comprised a description of each stage, the associated emotions, and educational needs. For example, an APN may associate being a competent nurse with a feeling of being on a roller coaster “with both nerve-wracking times and good experiences.” Educational needs for this stage include “opportunities for involvement in problem solving and change.”

Benner’s model is also relevant for ethical development of nurses. Benner writes that ethical conduct in everyday practice is experientially learned. In essence, a nurse must learn how to respond to ethical situations as someone who is an ethical expert would and to experience the “socially appropriate sense of satisfaction or regret” with the outcome of his or her action.

Perception of ethical issues depends on the nurse’s stage of expertise. The beginner’s sense of moral agency (the sense of one’s possible impact and influence on the situation) consists of achieving pre-set goals, accomplishing tasks, and being respectful and considerate. Separation between legal and ethical issues may be hazy. At the expert level, nurses are better able to make qualitative distinctions between patient conditions, such as psychological withdrawal or decreased consciousness.

By discussing ethics in terms of the nurse's understanding, staff development instructors can more easily help nurses learn how to deal with complex situations, such as a patient’s end-of-life decisions, that can lead to moral distress. Ethical issues and moral distress can affect staff teamwork and retention. One study found that 15 of the nurses in the study (n=214) had resigned a position in the past because of moral distress.

A Manager’s Responsibility

All nurses are responsible for creating a positive, healthy work environment, yet managers have a special responsibility. For example, they can integrate assessment of nurses’ skill levels into planning, particularly staffing, so that nurses can more easily develop their expertise. Strategies to encourage development of expertise include creating a learning environment, implementing clinical development programs that recognize various levels of expertise, and integrating clinical narratives into practice. These narratives should address successes and situations in which the outcome was negative.

Nurse managers should choose preceptors carefully and ensure they receive formal education for the role. “The people you seek out to solve a tough problem are often the best preceptors, but not if they don’t like to teach or aren’t good at coaching the new nurse,” Benner says.

Nurses and Physicians

The ability to collaborate with physicians varies with expertise. Other factors may include self-confidence and communication skills. Understanding differences in collaboration abilities helps avoid
conflicts and improves patient safety. For example, a beginning nurse will likely report “the facts” of a situation to the physician, without being able to give appropriate weight to the most important facts. Therefore, the physician may overlook key nuggets of information about a patient’s condition.

Standard tools can promote effective communication between nurses and physicians, particularly with nurses in early stages of developing their expertise. One such tool is “SBAR”: Situation (what is happening now with the patient); Background (what led to the situation); Assessment (what the problem is; the nurse’s evaluation of the situation); and Recommendation (what needs to be done to correct the problem).

**A Model for All**

Benner’s work provides a framework that supports lifelong learning for nurses, making it relevant for practice, research, and education. It has even been applied to professionals in other disciplines, such as dietitians.

Understanding the five stages of competence can help nurses support one another and appreciate that expertise in any practice depends on experiential, situated learning over time. And, as Benner says, “The more supportive you are, the better your own job will be.”

*A fictional case study.*

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**References**

1. Nightingale F. Letters July 23 and August 1, 1861. Located at: Nursing Spectrum Continuing Education, Falls Church, VA.


