Validation of the Adams Influence Model (AIM)

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Boston College

William F. Connell School of Nursing

VALIDATION OF THE ADAMS INFLUENCE MODEL (AIM)

a dissertation

by

JEFFREY MATTHEW ADAMS

Submitted in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

December 2008
Abstract

Understanding Chief Nurse Executive (CNE) influence is essential for the discipline of nursing. There are approximately 5000 CNEs in the United States, all are tasked with being the primary identifiable leader representing organizations in which they are employed and the nursing profession of which they are a part. In this capacity, the CNE is the gatekeeper for the advancement of the majority of the 2.4 million nurses practicing in the U.S.

Literature suggests that early CNEs lacked influence and often were not recognized members of organizational executive teams. Today, after two decades of struggle, CNEs are identified as essential executive team members. However, they still self identify as being less influential than their C-suite counterparts, leaving us to question, “Having gotten to the table, now what?”

This study was designed as an initial step toward answering this question through Validation of the Adams Influence Model (AIM). The AIM is a framework that can be used to understand the influence of the CNE in the acute care setting. The study exposed the AIM to a qualitative data set collected as part of an academic medical center’s Survey of the Professional Practice Environment. Directed content analysis was used to categorize survey responses and identify influence content toward validation and refinement of the AIM’s operational definitions.

Study results validated AIM influence factors and influence attributes with some refinement. In addition to development of a refined AIM, study findings also helped identify continued research opportunities. These research potentials included the exploration of; influence instrument development, the influence process, differences between influence and power, and the relationship between CNE influence, work environments and patient outcomes. As a discipline, nursing must continue to understand the influence of the CNE. These individuals are leading the profession, at what pace and in what direction cannot be left to chance.


**Dedication**

This manuscript has been completed because of **Alicemary Aspell Adams**. Alice, two schools, three children, four states, five years, six houses, hundreds of doctor’s appointments, and thousands of miles traveled since I’ve started…now we’re finally here. As in most instances…I’m the one that will get most of the recognition, but you are the one that did the heavy lifting. Thank you, now it is your turn! I hope I can be nearly as supportive as you have been. **Tieren, Kallen & Sabine**, you’ve sacrificed a lot too. I am very, very lucky to be your Dad.

**Acknowledgements**

During my career and education, I have been blessed with the opportunity to interact with and be influenced by some of the most well respected educators, researchers, practitioners and people that nursing and the world has to offer. First and foremost in this category is my advisor, **Dorothy Jones**, there are not words that can express how much I have learned from and because of you. You are a wonderful teacher. I know what you did for me taking me on. I am very thankful and more than proud to be a disciple. **Jeanette Ives Erickson**, I am so lucky to continue to be mentored by you. It is inspiring to know and interact with people who are the best at what they do. Thank you for including me with openness in your span of influence. While I know you will never say what your expectations are for me…I know you have them, and I do hope to live up to them. **Joyce Clifford**, thank you for opening the doors of your world to a student set on understanding the nurse executive population. You are among the few to set the groundwork for my interest in understanding and developing nurse executives. You have shared many of your lived experiences which have kept me motivated and on track. **Danny Willis**, thanks for sharing your understanding, positive outlook and expertise. I look forward to joining you in influencing our nursing profession for many years. **Carrie MacLeod**, thanks for going first, keeping me motivated and moving forward. I can’t thank you enough for your comments, edits and most of all friendship.
During my doctoral study, I have been supported through a Pre Doctoral Fellowship through the Yvonne Munn Center for Nursing Research at Massachusetts General Hospital. This Fellowship has allowed me to fully explore the experience of doctoral study. I am grateful and indebted to Jeanette, Dottie and the Yvonne Munn Center team for the unique and fulfilling experience.

There are many others that played a key role in my interest in nursing, influence and doctoral study. So thank you to:

- **Janice Linberg** for talking me into a career in nursing.
- **Ada Sue Hinshaw** you have shared more opportunity with me than I certainly deserve. You directed me down a yellow brick road of wonderful experiences.
- **Linda Aiken**, it is clear now, you were the wizard Ada Sue wanted me to find.
- **Julie Sochalski**, for the great conversations, teaching me so much, and giving me perspective. Hunting you down was so well worth it!
- **Cynthia Scalzi**, for helping me to explore my tangents in education.
- **Marianne Ditomassi, Roy Simpson**, and **Nancy Stryker** for helping me see some of the opportunity that nurses have to really influence the world around us.
- **Ellen Marie Whelan**, for your continued inspiring friendship. I am so proud to even know you. I always appreciate talking with you and hearing how you make a real difference.
- **Gail Keenan**, for helping me to get going and focus, I hope I can emulate your style.
- **Sandra Mott**, for sharing the idea of directed content analysis.
- **Sr. Callista Roy**, for helping to structure my thinking and for teaching me things that I would have never known existed. You certainly caused me to adapt my worldview.
- **Lois Skillings**, for sharing your enthusiasm. You are continually motivating!
- **Elizabeth Goch, Ginger Renkiewicz**, and **Kathy Vestal** for helping me with understanding female health care executives and the potentials for research in this area.
• Irene Neumeister, John Haffty, Ginny Williams, Lori Oliphant, Lisa Paulo, Doreen Faiello, Debra Denham and the nurses & professionals at Salinas Valley Memorial Hospital for creating such a wonderful professional practice/work environment.

• Imogene King for your unconventional motivation. I am glad we connected and I am deeply saddened we will not have interacted more.

• Jon & Amy Kirchoff for validating that going back to school was a good “family” idea.

• Thomas & Maureen Aspell for not rolling your eyes too much when this disabled guy asked to marry your daughter and took her on his educational journey across the U.S.

• My classmates, especially Kelly Grady, when they talk about footprints in the sand… I am sure it is easy to identify the spells where you and Carrie dragged me along!

• Diane Carroll, Sandie Cortes, Deb Fallon, Maureen Greenberg, Zanifer John, Linda Lyster, Linda Plummer & Karen Poznick for working through my logistical challenges.

On a very personal note, thank you to Peggy Knuth for showing me many years ago what good people do when others put them in a bad situation. Thank you, Rob Ogarek, for being my lifelong friend and for never wavering when I needed a friend most. Travar Pettway, when I was a kid, I would have never anticipated that a tough African American teen from inner city Detroit would turn out to be the single most inspirational man I will likely ever meet, but you are just that.

I’d lastly like to share my love and appreciation for my family, especially my parents, Tony and Kathy Adams, brother Todd Adams and grandmothers, Mary Jane Adams and Jennie Hoffman. You have been great teachers and friends. Thanks for sharing so much and for always expecting something more than average. I’d like to especially recognize my grandfathers, Arthur Adams, EdD and Edward Hoffman, MD who set my educational expectations for a terminal degree. Poppi & Grandpa, I know you are smiling…believe me, I am too!

I do hope anyone reading even a part of this manuscript finds it nearly as interesting as I found the process of learning how to put it together.
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CHAPTER ONE - OVERVIEW

Introduction

Today’s healthcare organizations employ a myriad of leaders in roles with various responsibilities and workloads. The Chief Nurse Executive (CNE) is faced with the most complex of these roles. There are approximately 5000 CNEs in the United States (Health Forum, 2006). These five thousand professionals are tasked with being the primary identifiable leader influencing excellence in both the organization they are employed and the nursing profession of which they are a part (Fedoruk & Pincombe, 2000). In this capacity, the CNE serves as the gatekeeper for the advancement of the majority of the 2.4 million nurses practicing in the U.S. (Bureau of Labor Statistics, 2007), while striving to promote continuous improvements in advancing safe, patient-centered, timely, efficient and cost-effective quality care (Clifford, 1998; Institute of Medicine, 2001).

Over the past quarter century, the significant influence of nursing leadership within an organization (Clifford, 1998; Poulin, 1984) and on work environments (Laschinger & Havens, 1996) has been discussed in the literature. Recently, several prominent nursing leaders have suggested that organizational nursing leadership is vital for enhancing nurses’ work environments and positive patient outcomes (American Nurses Association, 1995; Institute of Medicine, 2004; McClure & Hinshaw, 2002) and essential to ensure excellent patient care (American Organization of Nurse Executives, 2005). While the CNE in healthcare does influence the organization, workforce and patient outcomes (Farrell, 2004; McClure & Hinshaw, 2002), very little is known about the influence of the CNE role on nurses in particular, more specifically the qualities and
characteristics that support the CNE in influencing continuous organizational and professional improvements.

The Adams Influence Model (AIM) was developed and advanced through literature reviews, pilot testing and content validating dialogue with CNEs and nurse researchers for over a 5 year period. The AIM development efforts to date have focused on the identification of characteristics of the CNE role and the evaluation of these factors as they relate to CNE influence within the healthcare organizations. To date, the AIM has not been exposed to testing and refinement when examined against professional staff data. Therefore, the purpose of this study is two-fold: A) to test and refine the Adams Influence Model through exposure to an external data source, and B) to gain new knowledge about the influence of the Chief Nurse Executive (CNE) and her/his executive team through secondary data analysis of a survey evaluating the staff perception professional practice environment.

Background

Historically, nurse executives in the U.S. were selected to function in their roles often based upon social stature, educational preparation (household management) and acceptance by male administrators and physicians (Godden, 1995). Given these beginnings and the subsequent professional challenges requiring executive level professional representation, nurse leaders as well as nurses in other roles within health care organizations have been depicted by others and self-described as less than influential (Adams, Duffy, & Clifford, 2006) or powerful as a professional group (Sullivan, 2004).

Today, most CNEs have achieved an organizational status equivalent to peers within the executive leadership team. The CNE position has become a clearly established
entity by governing and regulatory bodies (Dwore, Murray, Fosbinder, & Parsons, 2000) including the Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission, 2007) and the Institute of Medicine (Institute of Medicine, 2004). While nurses have “made it to the executive table” little is known about the experiences, qualities and characteristics of CNEs, how their successes are appraised and unique contributions brought forth to the executive team when CNEs are evaluated by professionals.

Nurse Executive evaluation and research to date have been sporadic and somewhat disjointed. CNEs have primarily been studied tangentially, integrated into a design of work environment or organizational outcomes studies seemingly as an afterthought. Existing research emphasizes CNE characteristics around leadership or management style, decentralized decision making, and/or collaboration and cohesion. (Huber et al., 2000; Price & Mueller, 1981; Upenieks, 2002) as opposed to identification of personal qualities or factors that can be stressed in education and job role descriptions and thus evaluated to enhance the effectiveness of the CNE role.

Most of the literature about CNEs and their role often use descriptive qualitative methodologies to depict the function and characteristics of this role. These studies fail to address influence, success or isolate factors that more effectively define the CNE. Descriptive, theoretical and/or experiential reporting often provide most of the current information about today’s CNE. More rigorous research, with an emphasis on the CNE experience may yield data providing a beginning picture of specific characteristics viewed as valuable for CNEs in this role. To date, most CNE research has primarily used data to isolate individual themes such as: empowering leaders (Laschinger, Wong,
visionaries (Farrell, George, Brukwitzki, & Burke, 2002); and persons with self
confidence (Allen, 1998) as single entities across the global nurse executive practice. 
These studies fail to synthesize data to describe the collective criteria or strategies 
required to describe an influential and ultimately successful nurse executive, on an issue 
by issue basis.

Recently, there has been literature which has begun to lay a foundation towards 
isolating characteristics that may provide a new conceptualization of the CNEs and their 
influence on a system. Additionally, these writings have also defined a plan to help the 
CNE understand and achieve success. Research conducted in 2000 and 2003 by Ballein 
Search Partners, in conjunction with the American Organization of Nurse Executives 
(AONE), described a profile of the modern nurse executive leader (Ballein, 2000; Ballein 
& Thompson, 2003). In 2005, AONE released its core competencies for nurse executives 
(American Organization of Nurse Executives, 2005). These competencies were designed 
to provide an inclusive list of skills needed to promote nursing leadership and CNE 
success. A detailed list of the AONE Core Competencies can be found in Appendix A.

Farrell (2004) suggested that staff perceptions of the CNE was a useful way to 
identify competency of the CNE. Adams et al. (2006; 2007) surveyed attendees at the 
Institute for Nursing Healthcare Leadership (INHL) Conference to better understand 
those CNE competencies requiring the greatest amount of CNEs time. These studies also 
focused on the self perceived knowledge and influence that CNEs felt they had, in 
comparison to fellow nurse leaders and non-nurse healthcare executives around key
nursing administrative management issues impacting the CNE role within their organization.

Existing research on the CNE role holds promise as it creates a new way to define, understand and evaluate influence in the CNE role. This evolving focus on the impact of the CNE may enhance role clarity for the CNE and lead to the development of new research needed to generate universal measures that can evaluate the influence of the CNE on an organization to describe success. Toward this end, a conceptual model, The Adams Influence Model (AIM), with a focus on the CNE role, will be tested using secondary data to evaluate CNE and executive leadership. These data will help isolate and support important characteristics that can be included in curriculum and used to recruit, retain and evaluate the effectiveness of the CNE.

Purpose for this Study

The primary purpose of this study is to validate and/or refine the literature-based Adams Influence Model following secondary analysis of qualitative data collected as part of a large medical center’s evaluation of the Professional Practice Environment. Within this context, the following questions will be asked:

1. What influence concepts, as defined by the AIM, are identified by a nursing and multidisciplinary professional staff as necessary for the CNE and patient care services executive team seeking to maximize the professional practice environment?

2. What are the influence factors and influence attributes identified most frequently by multidisciplinary professional staff responding to the Professional Practice Environment survey?
3. How does data from this analysis support or refute the factors, attributes and related definitions as described within the AIM?

Significance and Assumptions

The state of Chief Nursing Executive education, role and practice in the United States is at a critical juncture. A 2005 study, funded by the American Organization of Nurse Executives found that approximately 40% of CNEs experienced “turn over” at least one time during their career, with approximately 62% of the CNE respondents reporting that that they anticipated making a job change in less than 5 years (Thompson, Jones, & Havens, 2006). This high turnover rate has often been associated with a lack of role clarity, undefined expectations and measures to evaluate the CNEs success. Compounding this problem, recruiters and recruitment firms charged with filling these vacancies have often used varying criteria when seeking CNE candidates causing significant role and disciplinary confusion. Clark and Lang (1992) have noted if you cannot name it, you cannot “measure it, control it, finance it, teach it, or put it into public policy.” This fact remains true of the nurse executive practice. Without clear delineation of nurse executive autonomy/governance, compensation, education and succession/retention, challenges remain in evaluation of those in the CNE role. A universally accepted, standard definition of the nurse executive leader roles and responsibilities would help to generate unity around a CNE role and could be used to develop a report card for the evaluation of CNE across institutions. Drawing upon findings from this study, current and future nurse executives can create an inventory of competencies and qualities needed to enhance influence, set expectations and ensure them success in their roles.
Today, Nursing Administration education provides fewer opportunities for formal discovery and knowledge dissemination, increasing the emphasis on maximizing the knowledge and skills of current and future Nurse Executives will serve to improve role clarity. While educational criteria for Nursing Administration has been identified (Dienemann & Aroian, 1995), preparation for the role of nurse executive has been diverse. Career paths for CNEs do not always include formal executive or internship training. Rather staff work experiences are highly valued in the effort to fill the role of CNE. This is significantly different than experiences expected of other members of the “C-suite”.

The current study stemmed from the author’s personal experiences with this cycle of uncertainty in organizational leadership and the CNE role. In particular, consulting experiences in which the author has experienced both “influential” and “ineffective” nurse leaders in organizations. Many times, the nursing department was the recipient of decisions made by a CIO, CFO or CMO. This occurred despite nursing leadership representation on the decision-making team and their role in implementation of these decisions. This led the author to ask, “What makes some nurse leaders have more organizational influence than others?”

Two preliminary studies by Adams and colleagues (2006; 2007) found that nurse leaders identify non-nurse healthcare executives as more knowledgeable and more influential than fellow nurse leaders within their same organization. The 2007 study also identified that when nurse executives and directors groups were isolated, both aggregate groups self identified as being less knowledgeable and influential non-nurse healthcare executives (Adams et al., 2007). These findings coupled with Yukl & Falbe’s (1990)
identification of influence as a key determinant in motivating staff, securing support from
staff and administration, accessing resources and affecting decision making throughout
the organization, have been the impetus for this research investigation. It is hoped that
current findings contribute to the development and evaluation of a model for
understanding, defining and enhancing influence within the chief nurse executive and the
executive leadership group.

The nurse executives’ responsibilities as organizational administrator and
professional ambassador foster them working toward the simultaneous betterment of both
the organization and the profession. While the CNE may develop organizational goals to
that end, resource management and financial needs often compromise their
implementation. As a leader of the nursing profession, the CNE knows that
distinguishing the complexity of nursing care from patient care can be difficult to isolate
as independent elements and quantified in strictly monetary terms. The ability of the
CNE to influence the system leadership, increase nursing documentation and support
nursing’s ability to increase its visibility within an organization is critical and will help
the CNE to better articulate practice goals, intended outcomes and needed resources.

The present study of nurse executives and her/his influence within the
organization identified characteristics that support patient outcomes, and enhance the
staff perceptions of the work environment. Additionally, the findings support
relationship between and among organizational structure and administrative
characteristics that are needed to enhance the CNE and the executive leadership
achieving desired outcomes. This work offers an opportunity to standardize the role of
the CNE in for-profit and not-for-profit, academic medical centers and community
hospitals alike. This standardization of core competencies and constituent expectations of the CNE role allows for consistent evaluation at national or international levels. Defining universally accepted evaluation criteria helps guide academic preparation of CNEs globally while reintroducing this important role into nursing education at the advanced level. To accomplish these goals, it will be important to create and adhere to a unitary focus within the discipline of nursing and to define universally accepted expectations for those in the CNE role. Results from this study focusing on the testing and validation of the Adams Influence Model can enhance the influence of Chief Nurse Executives toward defining universally expectations for those in this role.

Summary

Chief Nurse Executive roles in the United States have expanded significantly over the past quarter century. Some CNEs have in fact, emerged as some of the most influential leaders in healthcare. However, there is little literature, related research or existing frameworks that clearly identify and/or isolate the characteristics that make these CNEs influential. The Adams Influence Model was developed over a five year period as a knowledge-based framework toward eliminating this gap in nursing literature and practice. As a discipline and profession, nursing must continue to advocate for and measure the success, influence and impact of the CNE. These individuals are leading the profession, at what pace and in what direction cannot be left to chance. This study designed to validate the AIM is an early step in this research trajectory.
CHAPTER TWO - REVIEW OF THE LITERATURE

Introduction

This literature review used in this study was guided by an interdisciplinary framework to advance the selection of materials for review. Consilience as defined by Wilson (1998, pg 8) is a “jumping together” of ideas and suggests that knowledge is unified across the sciences and the humanities. This literature review used knowledge crossing several conceptual areas and stemming from several disciplines in the effort to weave a picture of the importance of CNE influence on the clinical work environment.

This consilient framework was used, primarily to access the body of research aimed at understanding the CNE role, influence and effectiveness. This literature has been generally be described as inadequate. CNEs are the members of the executive team with responsibility for many things but the greatest percentage of time is often around organizational operating budgets. CNEs have reporting line oversight for nearly 1.4 million staff nurses (The Advisory Board Company, 2003), major research funding sources have not focused on studying the impact of the CNE within health care organizations. Sporadic and tangential CNE research does exist, but coordinated research within this population has been extremely limited. This lack of evidence has, in part, enhanced confusion over role expectations for the Chief Nurse Executive and has limited the development of measures of success for those in the role.

To provide background for this study, literature was reviewed across three related conceptual foci:

1. influence and issue-selling was explored to provide a conceptual understanding of the phenomenon influence
2. The emergence of the nurse executive role was reviewed to provide an overview of the primary subject population.

3. Work environments and existing description and measurement of CNE success were explored to identify focused examples and opportunities for measurement of CNE influence.

Influence

The concept of influence has been articulated within several bodies of literature. They include psychology, business/organizational studies, nursing, women’s studies as well as several of the sciences. This work has been predicated by the seminal work defining influence, by French and Raven (1959). The early literature review was expanded to include directional influence concepts (upward, lateral and downward) as defined by Kipnis and colleagues (Kipnis, 1976; Kipnis & Schmidt, 1988; Kipnis, Schmidt, & Wilkinson, 1980) as well as the influence tactics identified by Yukl & Falbe (1990). Dutton and Ashford’s concept of “issue selling” was reviewed to contextualize influence around a singular issue as opposed to a broad general level of influence (Dutton & Ashford, 1993).

A synthesis of the existing influence related literature resulted in a definition of influence to include the affect of one party (agent) on another party (target) (French & Raven, 1959; Katz & Kahn, 1966; Kipnis, 1976; Kipnis & Schmidt, 1988; Martin, 1995; Mowday, 1978; Yukl & Falbe, 1990). The concept of influence has been used as a noun [My parents think you are a bad influence.], a verb [The alignment of the stars influenced your decision], or an idiom [He was arrested for being under the influence of alcohol].
Within each example, the concept influence, refers to the ability to affect a person, thing or course of events (influence, n.d.).

*Interpersonal Influence*

When studying influence in nursing, particularly in relation to the chief nurse executive, the most appropriate focus of the phenomena, influence, is interpersonal influence. Interpersonal influence takes place between two people, within a larger system. Interpersonal influence is best defined as the ability of an individual (agent) to sway or affect another person or group (target) (French & Raven, 1959; Katz & Kahn, 1966; Kipnis, 1976; Kipnis & Schmidt, 1988; Martin, 1995; Mowday, 1978; Yukl & Falbe, 1990). Within an organization all individuals are potential agents and targets of influence (Allen & Porter, 1983). It is important to note that this characteristic also applies to a person influencing a group. Within a group the “true group leader” is the person one should make attempts to influence (Hopkins, 1964). By gaining influence over this person the remainder of the group will most often conform. Influence of the masses (mass media) also does exist but will be studied at future date.

*Directional Influence*

Social and organizational hierarchies are yet other aspects of influence. The direction of influence is inherently defined by these hierarchies. Directional influence based on organizational and social hierarchies in influence include:

- **Upward Influence** - an agent’s attempt to gain compliance from those at a higher level within an organizational structure (Kipnis & Schmidt, 1988)

- **Lateral Influence** – an agent’s attempt to gain compliance from an organizational equal. (Kipnis & Schmidt, 1988; Martin, 1995).
• Downward Influence - an agent’s attempt to gain compliance from a subordinate within an organizational structure (Kipnis & Schmidt, 1988; Martin, 1995).

Upward influence is identified as a key concept for research of most chief nurse executives. The importance of upward influence within the CNE population is related to the majority of CNEs being female (92%) (Ballein, 2000; Ballein & Thompson, 2003) and the association of the role within the context of women’s history in the workplace, and nurses’ identification as a repressed people (Sullivan, 2004). This thread is explored in more detail later in this chapter.

The executive role structure and the structure of the healthcare system traditionally served as a barrier to nursing influence, likely because of the female dominance in the career field. The absence or minimization of nursing involvement in the health care leadership structure has allowed physicians, healthcare administrators and third-party payers to control funding for healthcare (Sullivan, 2004) thereby limiting nursing’s influence in healthcare.

Single Issue Influence and Power

It is not unusual to hear in casual conversation that an individual is or is not influential or powerful. The broad concepts of influence and power are often used interchangeably. However, while they are related concepts, they are operationalized in a distinct manner within this study. Power within the conceptualization of the AIM, is the cumulative of being influential over many single issues and likely across domains. In contrast, influence within the AIM is focuses on a singular issue. This is an important distinction because, each individual is more or less influential based on any given single issue (Dutton & Ashford, 1993). An example of this might be “Chief Nurse Executive
A” being influential around the issue of nurse staffing ratios. This same “Chief Nurse Executive A” may not be influential around the issue of the details of wheelchair use. These concepts and detailed examples are highlights in greater detail within Chapter 3 of this manuscript.

**Influence Tactics**

Influence tactics are categories of behaviors employed to reach a desired outcome (Yukl & Falbe, 1990). Influence tactics are explained in greater detail within Table 1.

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<td>Pressure</td>
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<td>Upward Appeal</td>
<td>Has approval from higher management (Yukl &amp; Falbe, 1990)</td>
</tr>
<tr>
<td>Exchange</td>
<td>Explicit or implicit rewards offer (Yukl, Chavez, &amp; Seifert, 2005)</td>
</tr>
<tr>
<td>Inspirational Appeal</td>
<td>Emotional request or proposal (Yukl &amp; Falbe, 1990)</td>
</tr>
<tr>
<td>Coalition</td>
<td>Seeks the aid of others (Yukl &amp; Falbe, 1990)</td>
</tr>
<tr>
<td>Ingratiating</td>
<td>Gets one in a good mood (Yukl &amp; Falbe, 1990)</td>
</tr>
<tr>
<td>Consultation</td>
<td>Seeks participation in decision making (Yukl &amp; Falbe, 1990)</td>
</tr>
<tr>
<td>Rational Persuasion</td>
<td>Uses logical arguments (Yukl &amp; Falbe, 1990)</td>
</tr>
<tr>
<td>Collaboration</td>
<td>Working with target to carry out a request (Yukl &amp; Falbe, 1990)</td>
</tr>
<tr>
<td>Legitimating</td>
<td>Claiming an issue is consistent with policy rules or practices (Yukl &amp; Tracey, 1992).</td>
</tr>
<tr>
<td>Apprising</td>
<td>Explains how one would benefit directly from carrying out agent’s claim (Yukl et al., 2005).</td>
</tr>
</tbody>
</table>
Recognizing the personal factors that nurse executives can and need to use to exert influence is important to realize the CNE’s influence. Understanding the fact that influence tactics exist is vital to understanding the concept of interpersonal influence. In a pilot study (Adams, 2003) conducted with a group of female health care executives, rational persuasion and coalition tactics were identified as the two influence tactics most favored and employed by female healthcare executives.

**Issue Selling and Influence**

Influence is necessary to “sell” an issue. Issue selling is defined as one’s attempts to call organizational attention to key trends, developments and events that have implications for organizational performance. Issue selling, occurs when one breaks silence and speaks up on behalf of an issue (Dutton & Ashford, 1993; Piderit & Ashford, 2003). The concept of issue selling is heavily related to the influence tactics as described previously.

**Role of the Nurse Executive**

The application and understanding of the concept influence, begins with those who are tasked with motivating, securing support and resources (Yukl & Falbe, 1990). This is specifically the CNE who is often assisted by an executive leadership team within the acute care setting. The CNE can best be defined as a registered nurse often with graduate nursing education, who orchestrates and influences the work of others in a defined environment, most often healthcare focused, to enhance the shared vision of an organization or institution. (American Nurses Association, 2007). A first step toward understanding how the CNE influences and orchestrates is through exploring some of the challenges and complexities of the role.
The approximately 5000 CNEs (Health Forum, 2006) in the United States serve as primary leaders both within the health care organizations in which they are employed and the global nursing profession (Fedoruk & Pincombe, 2000). This role has evolved into one of the most complex activities within all of healthcare (Adams et al., 2006). The CNE often serves as the senior organizational official responsible for coordination of interdisciplinary professional practice (i.e. nursing, respiratory therapy, physical therapy, pharmacy, etc) and the maximizing of quality patient care, professional staff satisfaction and organizational cost-efficiency (Clifford, 1998).

The expansive and multifaceted focus of the modern nurse executive role is rather new. Early nurse executives in the U.S. were selected for their roles based upon social stature, educational preparation (household management) and acceptance by the male administrators and physicians (Godden, 1995). What emerged was a role often rooted in paternalism and the marginalization of women. Not surprisingly, over time nurses have been depicted and often described themselves as a less than powerful professional group (Sullivan, 2004). Organizational governance in many healthcare settings continues to echo this characterization even today. In 2005, nurse executive leaders self-reported both their overall knowledge and influence as less than their non-nurse executive peers within their same organization (Adams et al., 2006). This may be related to gender inequalities as nursing leadership continues to be female dominated (>90% female) (Ballein, 2000; Ballein & Thompson, 2003) with the implication that the CNE remains part of an oppressed group (Freire, 2000; Sullivan, 2004).

Despite these challenges, nurses have made significant progress in increasing their executive presence and opportunity to influence others. In 1983, the American
Hospital Association’s National Commission of Nursing (AHANCN) identified the CNE as an integral member of the executive management team (American Hospital Association, 1983). Prior to this, the majority of CNEs were not involved in organizational strategic planning nor were they at the table and responsible for their own departmental budget (Clifford, 1998).

Over time however, many organizations have elevated the CNE to a status equivalent to others on the executive leadership team. As a member of the senior executive leadership team, the CNE has become more solidified as a requirement of governing and regulatory bodies (Dvore et al., 2000) including the Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission, 2007) and the Institute of Medicine (Institute of Medicine, 2004). Still less than half of CNE’s have frequent interaction with the board of directors (The Advisory Board Company, 2003).

The Expanding Role of the CNE

While nursing’s participation in the executive management team has been rather recent, studies and analysis conducted by Ballein Search Partners (2000; 2003) and the VHA Nursing Leadership Council (2000) have suggested that the role and responsibilities of the CNE have also expanded exponentially. Within the current healthcare organization, the CNE is recognized not only as the senior leadership role responsible for nursing and nursing services, (Clifford, 1985, 1998; Poulin, 1984) but as the person often responsible for one or more ancillary service (Gelinas & Manthey, 1997).

A 1997-1998 study of restructuring in twenty-nine university teaching hospitals found that the CNE position had been transformed into a “patient care” executive
position, often encompassing nursing as well as additional clinical services (Ballein, 2000). Eighty-eight percent of nurse executive respondents to a 2002 Advisory Board Company study identified a broadening of the CNE role responsibilities, and 69% likened her/his role expansion to be comparable to that of the Chief Operating Officer (The Advisory Board Company, 2003). This role expansion is credited to those early nurse executives who represented the profession in executive settings and were able to provide needed evidence to support the CNE’s organizational value, enough to warrant expansion of the role.

While it can be argued that there is an inherent increase in the opportunity to influence with line authority over multiple disciplines, the expansion of the CNE role could potentially prove detrimental to the nursing profession. It has been suggested that this “role conflict” creates an ethical and profession challenge for the CNE (Adams, 2006; Clifford, 1998). The potential dilution of the expanded nursing leader’s focus with responsibility for respiratory, laboratory, rehabilitation, pharmacy, nutritional and other ancillary and support therapies in addition to nursing has the potential of creating fragmentation in the single unified voice of/for the nursing discipline. This challenge highlights the need for a universally accepted definition for success for those in the CNE role (Adams, 2006).

CNE Success: Where to Focus Influence?

Research measuring or even literature defining CNE success, is virtually non-existent. From an academic or professional nursing perspective, success for early Chief Nurse Executives was seemingly focused on overcoming social and historical barriers “to get to the table” (Adams et al., 2006; Sullivan, 2004). Over the past quarter of a century,
nurses have made great strides to solidify their involvement in the leadership team (Ballein & Thompson, 2003; Havens, 1998). The question now is, “Having gotten to the table, now what?” (Adams et al., 2006).

Currently, CNEs are evaluated based upon different criteria set by subordinates, peers and superiors as well as institutional characteristics such as for profit status. These complex and compounding variables make a universally accepted standard of success for CNE difficult to identify or measure. While the AONE Core Competencies as listed in Appendix A, provides an initial framework for knowledge and skills valuable to nurse executives, they are expansive in nature, and stop well short of providing strategies to influence or define success (American Organization of Nurse Executives, 2005) in the CNE role. The proposed Nursing Administration: Scope and Standards of Practice (2007) as listed in Appendix B, go a step further and provide sixteen standards with general measurement criteria for Nursing Administrative Practice, but fail to identify a quantifiable measure of success for evaluating each standard.

The Nurse Executive and Outcome Measures

An argument has been made over the past quarter century that nursing leadership can and does significantly influence the organization (American Nurses Association, 2004; Clifford, 1998; Poulin, 1984) and work environment. Clifford (1998) identified that when nurse executives in the 1990’s experienced restructuring and a reduction of organizational influence, the impact was felt throughout nursing chain, including directors, managers, and staff. All perceived that access or representation of the profession at the top levels of the organization were no longer available. More recently, several publications have taken this one step further and have suggested that
organizational nursing leadership is vital for enhancing nurses work environments toward producing positive patient outcomes (American Nurses Association, 1995; Institute of Medicine, 2004; McClure & Hinshaw, 2002). The nurse executive sets the vision and direction toward providing quality interdisciplinary care (American Organization of Nurse Executives, 2005; McClure & Hinshaw, 2002). This prominent work environment criterion is valued by all constituents, executives, peers and subordinates, and can be used as a measure toward the evaluation of CNE success. Work environments are especially valued because they have been shown to correlate to patient outcomes, which is the gold standard measure of success for healthcare organizations (Adams, 2007).

Current literature reflecting the state of the science discussed thus far has identified that positive nursing leadership fosters positive practice and work environments (American Nurses Association, 2004; Clifford, 1998; McClure & Hinshaw, 2002; Poulin, 1984). It has also been well documented that positive practice and work environments promote better patient outcomes (Aiken, 2002; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Aiken, Smith, & Lake, 1994). Thus, it is not a monumental leap to hypothesize that the Nurse Executive has an impact, albeit indirect, on patient outcomes. There are several potential avenues of exploration stemming from the review of literature. However, within the context of this study, the literature reviewed aimed at the interrelationship between CNE influence, the professional practice/ work environment and the actual or potential impact of the CNE or PPWE to patient outcomes. Each factor will be discussed in pages 26 to 42 to follow.
Nurse Executive Influence on Work Environments

A literature review of nurse executive leadership, work environment and patient outcomes was completed using the research databases Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Pubmed. A systematic analysis ensued. The conceptual sub-components of the AONE competency areas (American Organization of Nurse Executives, 2005) were initially used as key words in this search, both individually and in conjunction with the concepts “nurse executive”, “nurse administrator”, “nurse leadership” and “magnet hospital”. The reviewed articles included original research conducted in acute care institutions within North America. Studies included in this analysis were limited to those published over a ten year period (1997-2007). Following a preliminary analysis of forty-seven articles identified during the search, a total of eleven were selected, based upon specific reference(s) to nurse executive/ leadership practice in conjunction with clinical practice, nurses work environments and/or patient outcomes. Demographics, study design, data collection methods, data analysis, discussions and conclusions of the studies were evaluated. Findings relating to nursing executive leadership practice and influence or potential influence on the work environment were extracted from each study. This information was then synthesized to identify opportunities to measure the nurse executive influence on the work environment.

Evaluating the Nurse Executive’s Influence on the Professional Practice Environment

The literature reviewed suggested that nurse executive leaders have not been included as an explicit component of work environment measurement tools, and they have only been tangentially studied in quantitative research. Within those studies using qualitative or mixed methods, (Adams et al, 2006; Adams et al, 2007; Allen, 1998;
Clifford, 1998; Upenieks, 2003c), the majority of publications reported nurse executives and nurse executive practice using descriptive, theoretical and/or experiential reporting, falling short of identifying how the CNE influenced the work environment. None of the articles provided a general definition of “success” for someone holding this role.

Nurse Executive Power and Empowerment

Laschinger and colleagues (1999) identified that powerful/influential leaders created a sense of empowerment among subordinates and enhanced an environment of power. In contrast, powerless managers tended to be micromanagers and foster a demotivating environment (Laschinger et al., 1999). Laschinger and colleagues (1999) and later Patrick and Laschinger (2006) operationalized Kanter’s theory of empowerment that suggests “power begets power” (Kanter, 1993) when given the opportunity in nursing environments suggesting that when nursing leadership extends power/authority to subordinates they themselves gain power within their organization. Patrick and Laschinger (2006) building upon Kanter’s work identified that nurses who experience empowerment structures and/or perceptions of organizational support have increased satisfaction in their role suggesting an influence on the work environment.

Havens (2001) identified that decentralization of power and collaborative decision making structures existing in Magnet hospitals (in contrast to non-Magnet hospitals), resulted in a difference in work environments. This research was based on the premise that there are differing organizational structure/characteristics in hospitals known for positive patient outcomes (Aiken et al., 1994) and quality practice/work environments (Havens & Aiken, 1999; Scott, Sochalski, & Aiken, 1999). The results of these studies
suggest that when power is shared through a collaborative decision-making model, specific organizational leadership characteristics can be identified.

While the previous research reviewed offered evidence that an empowered nurse executive leader can create a positive practice/work environment, two studies (Adams et al., 2006; Havens, 1998) also identified that empowerment at the nursing executive level in general and throughout the healthcare setting, is generally lacking. Havens (1998) described a decrease in nursing involvement in executive level governance over the six year period (1990 – 1996), as reported by nurse executive leaders. This research was conducted during a time of intense healthcare consolidation and restructuring during the mid-1990s and it was hypothesized that the general health care environment may have influenced study results.

Nearly a decade later however, Adams and colleagues (2006) found that nurse leaders responding to a survey distributed at the 2006 Institute for Healthcare Leadership Conference, self-reported that non-nurse healthcare executives were both more knowledgeable and more influential than nurse leaders within their primary employment organization on 10 of 11 areas of management as defined by nursing administration content experts. These findings were again supported in a follow up study (Adams et al., 2007). The findings related to nurse executive governance/impact challenges still exist and may be related to the historical and social feminist roots and challenges of nursing previously identified in this manuscript.

*Organizational Commitment and Influence*

Manojlovich (2005) noted that organizational commitment can enhance the CNE’s ability to influence the work environment. This research supporting Kanter’s
work identified that supportive work environments enhance employees’ ability to accomplish work. Manjlovich suggested that structural empowerment through self-efficacy can lead to improved professional practice behaviors within the CNE population. However, other literature encouraged the need for more work before Kanter’s and/or Manjlovich’s findings are universally translated to practice.

**Role Complexity of the CNE and Influence**

The complex and multi-constituent nature of the CNE role was highlighted in The Advisory Board Company study (2003), where just over 50% of CEOs describe their CNE as strong performers. Even more concerning, was that within the same study, only 21% of staff nurses rated the CNE as being a strong performer, and only 7% of staff identified an excellent relationship between frontline nurses and senior nursing leadership (The Advisory Board Company, 2003). This research suggested that CNEs may be doing a better job of keeping their bosses happy rather than their employees. However, because of CNE role complexity, the nurse executive may not be meeting the expectations of either constituency.

Wieck and colleagues (2002) highlighted another issue for the CNE working to influence a complex work environment. They identified a trend in nursing, which is occurring across business sectors, namely that significant generational differences exist, in this case, within the nursing profession. The new, younger generation nurse seeks role autonomy, control over practice, and visionary leadership. Whereas, more senior nurse employees may be more likely to accept more authoritative leadership (Upenieks, 2003a). The potential is that the CNE needs to be able to influence the environment so that both perspectives are addressed.
Leadership Characteristics and Influence

The majority of research discussed thus far has highlighted challenges for the CNE. There were articles that focused on means of “how” the CNE could increase her/his influence. Allen (1998) identified several characteristics as important for a leader to be successful in fostering a positive environment. They included self-confidence, personal leadership qualities, progressive experience and successes, exposure to significant persons and personal life factors (Allen, 1998). The single most articulated trait identified by Allen, was that of self-confidence. Self confidence was described as the “cornerstone,” essential for leadership development especially for the nurse executive. This self-confidence was developed through several means including: mentorship, personal interaction, opportunity, and success in risk-taking.

Upenieks (2003c) built on earlier work of Allen, (1998), and Havens & Aiken (1999), and identified specific organizational attributes that assisted CNEs in producing an empowered environment. These included organizational attributes such as support for nursing practice, good nurse-physician communication, decentralized decision making, flat organizational structures and CNE participation within the senior executive committee(s) (Havens & Aiken, 1999). The results of the Upenieks (2003c) study noted that hospitals that have achieved Magnet status employ leaders who are people-oriented, visible and empowering. These leaders aid in the development of an autonomous, supportive and collaborative work environment, through the balance of leadership
development and leadership traits that make one an effective as a nurse executive. Table 2 provides a summary of the literature reviewed within this section.

Tools emphasizing leadership, management style, decentralized decision making, and/or collaboration and cohesion do exist (Huber et al., 2000; Price & Mueller, 1981; Upenieks, 2003b). However, research involving work environment, patient outcomes and nursing executive leadership have existed in isolation leaving a gap in knowledge around their interrelationship and thus exploring opportunities to improve each of concept area individually and collectively. Limited research makes it difficult to provide a specific definition for CNE success. This being said, a synthesis of the available literature does suggest the practice/ work environment is a potential standard measure of CNE success, and a worthwhile issue on which the CNE should focus influence efforts.

Central Measures - Work Environment and Patient Outcomes

The importance of CNE influence on the work environment is supported through the significant body of literature which links organizations with positive work environments to improved/ positive patient outcomes. Much of this work is based on findings from the initial Magnet Hospital study (McClure, Poulin, Sovie, & Wandelt, 1983). This initial study led to the development of instruments that were tested, validated and adapted to measure and report on nurses’ professional practice/ work environment(s). Table 3 lists and describes these instruments.
<table>
<thead>
<tr>
<th>Publication</th>
<th>Methods</th>
<th>Framework</th>
<th>Applicable Measured Outcomes</th>
<th>Applicable Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Adams et al., 2006; 2007)</td>
<td>Mixed</td>
<td>None Noted</td>
<td>Self Perceived Knowledge, Influence and The Most Pressing Issues Facing Nurse Executive Leaders</td>
<td>Nurse executive leaders identify their nurse leader colleagues as less knowledgeable and less influential than non-nurse healthcare execs within the same organization. The most pressing issues for nurse leaders are contrasting as they can be categorized as Business Skills and Professional Practice.</td>
</tr>
<tr>
<td>(The Advisory Board Company, 2003)</td>
<td>Quantitative</td>
<td>None Noted</td>
<td>CEO satisfaction, Staff Satisfaction, CNO Authority/ Executive Representation</td>
<td>The majority of CEOs identify the nurse executive as a strong performer while less than one quarter of staff nurses rate the nurse executive as a strong leader.</td>
</tr>
<tr>
<td>(Allen, 1998)</td>
<td>Qualitative</td>
<td>Social Learning Theory</td>
<td>Self confidence, Leader Quality, Tendencies and Progression of Experiences</td>
<td>Self confidence was identified as a key in essential leadership development. This can be fostered through mentorship, personal interaction, opportunity and success in risk taking.</td>
</tr>
<tr>
<td>Publication</td>
<td>Methods</td>
<td>Framework</td>
<td>Applicable Measured Outcomes</td>
<td>Applicable Findings</td>
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<tr>
<td>(Clifford, 1998)</td>
<td>Qualitative</td>
<td>Contingency Theory for Managerial Work</td>
<td>Nurse executive leader role evolution, nurse executive inclusion in executive practice, Changes in nurse executive role and the impact on nursing services.</td>
<td>It is the role of the nurse executive leader to foster a cohesive/ unitary approach to patient care.</td>
</tr>
<tr>
<td>(Havens, 2001)</td>
<td>Quantitative</td>
<td>None Noted</td>
<td>Difficulty recruiting staff RNs Quality of patient care Organizational Support Degree of implementation of restructuring activities</td>
<td>There is a difference in magnet and non-magnet work environments.</td>
</tr>
<tr>
<td>(Laschinger et al., 1999)</td>
<td>Quantitative</td>
<td>Kanter’s Organizational Empowerment</td>
<td>Relationship between empowerment and accountability with a positive impact on work effectiveness.</td>
<td>When nursing leadership extends power to subordinates, they in turn become increasingly powerful.</td>
</tr>
<tr>
<td>(Manojlovich, 2005)</td>
<td>Quantitative</td>
<td>Kanter’s Organizational Empowerment &amp; Social Cognitive Theory</td>
<td>Structural Empowerment, Self Efficacy, Nursing Leadership, and Professional Nursing Practice</td>
<td>Organizational investment in leadership empowerment structures assists the nurse executive leader in influencing work environments.</td>
</tr>
<tr>
<td>Publication</td>
<td>Methods</td>
<td>Framework</td>
<td>Applicable Measured Outcomes</td>
<td>Applicable Findings</td>
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<tr>
<td>(Patrick &amp; Laschinger, 2006)</td>
<td>Quantitative</td>
<td>Kanter’s Organizational Empowerment</td>
<td>Structural Empowerment, Perceived Organizational Support and Role Satisfaction</td>
<td>Access to empowerment structures and perceptions of organizational support impact nurses role satisfaction</td>
</tr>
<tr>
<td>(Upenieks, 2003c)</td>
<td>Qualitative</td>
<td>None Noted</td>
<td>Self Reported Effective Leadership Traits, Elements of a successful organization, Maintenance of a successful organization</td>
<td>Magnet hospitals employ leaders who are people oriented, visible and empowering.</td>
</tr>
<tr>
<td>(Wieck et al., 2002)</td>
<td>Quantitative</td>
<td>Generational Conflict</td>
<td>Characteristics desired/ expected in leaders</td>
<td>Younger nurses seek to be led as opposed to managed.</td>
</tr>
</tbody>
</table>
### Table 3

**Nursing and Work Environment Tools**

<table>
<thead>
<tr>
<th>Tool</th>
<th>Developers/ Primary Citation</th>
<th>Subscales</th>
<th>Total Number of Items</th>
<th>Summary</th>
</tr>
</thead>
</table>
| NWI   | (Kramer & Hafner, 1989)      | 1. Management Style  
2. Quality of Leadership  
3. Organizational Structure  
4. Professional Practice  
5. Professional Development | 65                    | Initially intended to measure values relating to job satisfaction and the ability to provide quality care (Kramer & Hafner, 1989) for the individual. Expanded and used as a measure of a hospital's work environment (Kramer & Schmalenberg, 1991a, 1991b) |
| NWI-R | (Aiken & Patrician, 2000)    | 1. Autonomy  
2. Control Over the Practice Setting  
3. Nurse-Physician Relationships  
4. Organizational Support for Caregivers | 57                    | Derived from NWI – “nurses responses to a single item are summed to create a measure of an organizational trait...consistency is not based on the individuals response...but rather on the consistency with which each single item is rated by the aggregate group of nurses in that particular hospital (or unit). (Aiken & Patrician, 2000)” |

*table continues*
<table>
<thead>
<tr>
<th>Tool</th>
<th>Developers/ Primary Citation</th>
<th>Subscales</th>
<th>Total Number of Items</th>
<th>Summary</th>
</tr>
</thead>
</table>
| PES – NWI | (Lake, 2002)                                         | 1. Nurse Participation in Hospital Affairs  
2. Staffing and Resource Adequacy  
3. Nursing Foundations for Quality of Care  
4. Nurse Manager Ability, Leadership and Support of Nurses  
5. Collegial Nurse/ Physician Relations | 31                    | Derived from NWI – “used to measure the extent to which a nurse’s work setting facilitates professional nursing practice…” (Lake, 2002). |
| PNWE      | (Choi, Bakken, Larson, Du, & Stone, 2004)            | 1. Professional Practice  
2. Staffing and resource adequacy  
3. Nurse management  
4. Nursing process  
5. Nurse-physician collaboration  
6. Nurse competence  
7. Positive scheduling climate | 42                    | Developed from NWI-R added subscale of positive scheduling climate.                                                                |
| PPE       | (Ives Erickson et al., 2004)                         | 1. Handling disagreement & conflict  
2. Internal work motivation  
3. Control over practice  
4. Leadership and autonomy in clinical practice  
5. Staff relationship with physicians  
6. Teamwork  
7. Cultural sensitivity  
8. Communication about patients | 38                    | Developed to articulate contributions made by nurses as well as other health professionals within an organization (Ives Erickson et al., 2004). |
Nursing Work Index – NWI. The seminal measure of the nursing work environment, the Nursing Work Index (Kramer & Hafner, 1989), was initially designed to measure nurses’ job satisfaction as well as nurses ability to deliver high quality nursing care. The NWI was adopted as the basis for studying organization characteristics of hospitals (Aiken, Lake, Sochalski, & Sloane, 1997) and in doing so was used differently than the original intent of the tool (Aiken & Patrician, 2000). Subsequent studies led to a refined NWI, which was a 65 item scale set to understand organizational traits of hospitals that created an attractive environment for nurses. For each item within the NWI, nurses were asked to respond to each of three questions within each item on a 4 point Likert scale ranging from 4 (strongly agree) to 1 (strongly disagree). The three statements are: “This is important to my job satisfaction”; “This is important to my being able to deliver quality patient care”; and “This factor is present in my current job situation”.

Nursing Work Index – Revised (NWI-R). Refinement of the NWI led to the establishment of the NWI-R (Aiken & Patrician, 2000) in which the two NWI statements identified as “value” statements, and maintaining the single statement “This factor is present in my current job situation” were eliminated. The NWI-R included a conceptual item by item analysis to coincide with the intent of the revised tool. The NWI-R used 56 of the original 65 NWI items with one slightly modified (Aiken & Patrician, 2000). Aiken and Patrician (2000) also created a new item which focused on team nursing. Additionally four subscales, autonomy, control over the practice setting, nurse-physician relationships, and organizational support for caregivers were identified and included (Aiken & Patrician, 2000).
Practice Environment Scale of the NWI (PES-NWI) & Perceived Nursing Work Environment (PNWE). Other tool developers have also used or adapted the NWI with the intent of improving the measurement and understanding of work environments’ impact on nursing and patient outcomes. Lake (2002) used the NWI, as a source for developing a scale to measure the hospital nursing practice environment. Exploratory factor analysis was used on 48 of the original 65 NWI items meeting a definition of nursing practice environment (Lake, 2002). The PES-NWI contains 43 items of the NWI that were applicable to the social organization of the work setting. The results of this work led to the development of the Practice Environment Scale (PES) of the NWI (Lake, 2002).

Choi and colleagues (2004) developed the Perceived Nursing Work Environment (PNWE) tool. To do so, they used each of the subscales from the NWI-R, yet added a new subscale, Positive Scheduling Climate. Findings from related studies were supportive of previous NWI-R studies. The addition of the new subscale “Positive Scheduling Climate” was included to update measurement tools to reflect the evolving nature of the inpatient work environment (Choi et al., 2004).

Professional Practice Environment Scale – PPE. In 1998, the Massachusetts General Hospital expanded on existing work environment research and created The Professional Practice Environment Scale grounded in the hospital’s professional practice model (Ives Erickson, 2001; Ives Erickson et al., 2004). This tool measures items on a 4-point Likert scale similar to the NWI ranging from “strongly disagree” to “strongly agree.” Under each of the organizational characteristics, there is an overall satisfaction question pertaining to that specific organizational element, which is measured on a 6-
point Likert scale. At the end of the survey is a “Comments” section which allows for qualitative input to be entered and analyzed.

The PPE tool was developed some 20 years after the original NWI and includes several of the concepts and subscales as identified in previous NWI/ NWI-R studies, such as autonomy, clinician-physician relations, and control over practice. The expanded version of the PPE includes the subscales of Communication, Teamwork/ Leadership, Conflict Management/ Handling Disagreements, Internal Work Motivation, and Cultural Sensitivity. In addition, the PPE has been designed to evaluate the work environments of the nurse as well as each specialty within the interdisciplinary patient care services team, including, therapists, social workers, etc. In 2002, psychometric evaluation of the PPE described the tool as reliable and valid (Ives Erickson et al., 2004). In 2006, psychometric evaluation of the PPE was reevaluated because of slight word changes in the 2006 survey and a move to develop an online version of the PPE for use by professional staff. Results from the 2006 psychometric evaluation were remarkably similar to those found in 2002 (Ives Erickson, Jones, Duffy, & Ditomassi, 2008).

The use of these practice environment measurement tools have led to some of the most influential publications and translational organizational practices in nursing and healthcare. Studies published by Aiken and colleagues (Aiken, 2002; Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Aiken et al., 2002; Aiken et al., 1994) as well as Kramer and Schmalenberg (1988; 2002) are a major part of the current healthcare industry focus on quality, safety, work environments and outcomes. These researchers have identified organizations with positive work environmental factors such as RN educational level, low RN turnover and low RN to patient ratios, produce significantly better patient outcomes.
These practice environment measurements aid in the identification of situational and/or organizational relationships. They serve as a report card for the CNE and the executive leadership team as to effectiveness yet they have not been used to directly assess the influence of the nurse executive or clinical leadership on the nursing work environment. These tools and related literature reviewed described the nursing and professional practice environment with slight variation including organizational factors that influence nursing practice (Lake, 2002; Sleutel, 2000), the control over practice by nurses, the physical environment in which nurses work, and the overall culture and climate of an organization (Lake & Friese, 2006). The PPE added other patient care disciplines within this context. The definition of nursing practice environment is likely to vary across institutions, as CNEs may have significantly differing spans of control. A standard and universal definition of the professional practice/ work environments PPWE that is encompassing of the various role responsibilities of CNEs would aid in the measurement success for nurse executive leadership.

**Nurse Executive and Patient Outcomes**

As previously noted, prominent publications have suggested that the nurse executive plays a role in patient outcomes (American Nurses Association, 1995; Institute of Medicine, 2004; McClure & Hinshaw, 2002). However, linkages between the CNE and patient care outcomes have gone unexplored. Addressing this gap in the literature will likely have implications for nursing administration, graduate education, continuing educational preparation, workforce management, hiring practices/ criteria, nursing administration/ outcomes research and theory building.
Critique of Current Research Reviewed

The state of nurse executive leadership research is somewhat uncoordinated and disjointed especially in relation to practice/ work environments and patient outcomes. While the profile of the nurse executive leader has been established (Adams et al., 2006; Adams et al., 2007; Ballein, 2000; Ballein & Thompson, 2003) and the importance of nurse executive leader’s influence on nurses work environments (Clifford, 1998; Poulin, 1984) has been identified, literature has been limited to a handful of studies.

The consilient framework used for the literature reviewed to date, crossed multiple disciplines and highlighted the lack of influence, or the measurement and evaluation of influence in female executive populations. The concept of influence, as related to the CNE role in particular is not well defined. Nursing literature does however provide a general consensus surrounding the importance of CNE influence within an organization. Further, what makes one influential, and how can this influence be enhanced is primarily explored within psychology, business/ organizational studies literature. Application of this literature to the nursing discipline and particularly the CNE population provides a unique opportunity to understand influence in the female and female executive population as well as understand the importance of influence on the well being of the organization and profession. Nurses must continue to advocate for and measure the influence and impact of the CNE, because they are overseeing the practice of nursing on a day to day basis.
CHAPTER THREE – DEVELOPMENT OF THE AIM

Introduction

The impetus for studying influence in nursing stemmed from the author’s experiences working as a consultant to Chief Nurse Executives throughout the United States. Many times it appeared that these nurse executives took a back seat in decision making particularly around choices that impacted their role, for example, when clinical information systems were being evaluated for purchase, with the selection being deferred to a CIO, CFO or another in the C-suite. This lack of participation by the CNE, often resulted in the purchase or development of a system that did not capture nursing data or improve the work environments for nursing staff. These experiences led the author to question nursing’s and CNE’s organizational influence overall and in particular their role in leading these clinical information systems decisions. Further inquiry and discussion with nursing administration practice leaders and content experts helped identify the need for clarity around nurse executive influence. Furthermore, the belief that lack of influence was a systemic phenomena rather than something applied to a single issue, in this case clinical information systems selection, prompted the author to explore the CNE and influence on the discipline. Thus, the focus of the initial research was to define, model and articulate nurse executive influence to assist in improving nurse executive preparation, practice and organizational outcomes.

AIM Iteration One

The initial draft of the interpersonal influence model was developed in October of 2003 during initial doctoral study. This model and its operational definitions were based on the seminal influence work of French and Raven (1959), and Kipnis and colleagues.
(1988; 1980). When terms such as prestige or competency, were not defined by French and Raven or Kipnis and colleagues, the author used dictionary.com as a reference for operational definitions.

Iteration One of the Adams Influence Model (AIM) was developed with the intention of understanding nurse executive influence around the selection of the best clinical information system for nursing. A graphic representation of the AIM Iteration One can be found in Appendix D. This initial model was focused on influence of female executives given that the nurse administrator population has been identified as being greater than 90% female (Ballein, 2000; Ballein & Thompson, 2003). The model also incorporated the idea of directional influence.

- Upward Influence – to the senior healthcare executive
- Lateral Influence – to vendor/ CIS developers
- Downward Influence – to the nursing staff

Iteration One identified four influence factors - prestige/ interpersonal relationships, wealth budgetary control, ability/ competency, and position/ authority. These factors were identified as necessary to achieve the core construct “influence” and how the combination of these influence factors could be titrated to achieve influence with varying populations. The concept of influence factor titration suggests that given any single issue, and when addressing any single Influence Target, a CNE may possess or use greater or lesser amounts of any single influence factor category. An example of influence factor titration would include a nurse executive increasing the use of Position/ Authority when seeking to achieve influence around the single issue of enforcing subordinate employee dress code. Should the CNE be seeking to improve the appearance
of her/ his CEO (they regularly wear shorts to work), it is unlikely that position/ authority would be an effective influence factor to draw upon. Interpersonal relationships may prove to be a more effective influence factor in that instance.

A pilot study consisting of interviews with three female healthcare executives was conducted to begin to test, expand and validate the AIM. This study was designed to identify the female executives self reported scenarios where influence was achieved. Findings from this study led to the isolation of tactics used by the female healthcare executives and the perceived effectiveness of influence efforts (Adams, 2003).

AIM Iteration Two

The results of the pilot study led to further literature review of the concept influence and associated concepts, including influence attributes, influence tactics and influence styles (Kipnis & Schmidt, 1988; Kipnis et al., 1980; Yukl & Falbe, 1990; Yukl, Lepsinger, & Lucia, 1991; Yukl & Siefert, 2002; Yukl & Tracey, 1992). Figure 1 represented the second iteration of the AIM. It was presented in December 2005, and was based upon results of the pilot study and further literature review.

The AIM Iteration Two, expanded on the concepts identified in the AIM Iteration One. The AIM Iteration Two specifically added the concepts of:

- Influence Tactics - methods used to achieve influence (Figure 1 Section D)
- Influence Attributes – subcomponents of influence factors (Figure 1 Section G)
- Personal Influence Styles – categorization of individual types of influencer based on influence tactics (Figure 1 Section C).

Also identified and included in the AIM Iteration Two was the concept of a dyad relationship for influence (i.e. the CNE and the Target of Influence). Within this dyad the
target of influence (Figure 1 Section A) possesses the same influence factors (authority, status, interpersonal skills and competency) as the influence agent, i.e. the CNE (Figure 1 Section F). This change was an important addition, because it helped to clarify that the agent and target of influence possessed the same influence factors, potentially with different gradients.

Figure 1. Adams Influence Model – Iteration Two (December 2005)
Within the conceptualization of the AIM it was hypothesized that these differences may have an impact on the influence outcome. Within the AIM Iteration Two, influence tactics (Figure 1 Section D) were conceptualized as being variable, that is larger or smaller as rated by study participants.

In a pilot study, conducted by the author in 2003, participants identified the effectiveness of tactics for impacting influence. Thus, rational persuasion, coalition tactics, consultation and inspirational appeals appear larger than pressure tactics, ingratiating, and upward appeals in determining female executive influence (Figure 1 Section C). Influence tactics are explicitly defined in Table 1. Iteration Two also represented influence attributes or subcomponents of influence factors and influence styles. Influence attributes included the concepts of project responsibility, personal responsibility and financial responsibility as attributes of authority, reputation and relationships as attributes of status, communications, physical appeal, emotional investment and persistence as attributes of interpersonal skills, and knowledge, experience and education as attributes of competency. Influence styles include shotgun, bystander, ingratiator and tactician and are representative of general groupings for personal preferences or means for achieving influence.

The clarification of the AIM as a single issue influence model also occurred in Iteration Two (Figure 1 Section E). This suggested that the CNE may be influential about one issue, i.e. staffing ratios and not influential about another issue, i.e. clinical systems selection. Lastly, the concept of influence was represented as a compilation of influence factors depicted by combining of the shapes in Figure 1 Section B.
Feedback from students and faculty during Boston College doctoral coursework presentations suggested that although valuable, the AIM Iteration Two appeared overwhelming and complex. The author then reviewed the concepts contained within the model and consolidated concepts and refined layout to simplify and better articulate the influence message. This simplified model is depicted in the AIM Iteration Three.

AIM Iteration Three

The results from review and refinement of the AIM Iteration Two guided the development of the third iteration of the AIM. This version was developed in the spring of 2006 during doctoral study at Boston College Connell School of Nursing and based upon an extensive qualitative literature review and previous pilot testing. This review identified several new themes including, perception, knowledge, time, and timing that were added to the AIM and based upon discussion with nursing theory experts and the identified need for visual simplification of the model. The AIM Iteration 3 included the previously identified concepts Status and Authority, renamed and redefined the influence factors - competency to be knowledge based competence, and interpersonal skills to be interpersonal attributes and added the influence factor - situational, environmental & emotional awareness. A graphical representation of the AIM Iteration Three can be found in Appendix E. These changes were added as the result of continued review of influence related literature research (Dutton & Ashford, 1993) as well as coursework and seminar dialogue from Boston College Connell School of Nursing. Some influence attributes were also renamed to better articulate their meaning and associated with a primary influence factor (See Table 4) to provide operational definitions to the influence
factors. The updated influence factors and the associated influence attributes from

Iteration Two to Iteration Three are highlighted in Table 4.

Table 4

<p>| Influence Factor &amp; Influence Attribute Updates Iteration Two to Three |
|---------------------------------|------|----------------|----------------|----------------|</p>
<table>
<thead>
<tr>
<th>Influence Factor AIM Iteration 2</th>
<th>Status</th>
<th>Authority</th>
<th>Knowledge Based Competence</th>
<th>Interpersonal Attributes</th>
<th>Situational, Environmental and Societal Awareness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>4. Persistence</td>
<td></td>
<td>5. Confidence</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6. Perception of Target</td>
<td></td>
</tr>
</tbody>
</table>

Influence tactics were graphically consolidated within the Iteration Three AIM for purposes of visual simplification and overall clarity. The concepts of CNE/ nurse (agent) and target of influence were made explicit in Iteration Three as a refinement for this study. Lastly, the concepts of “perception of the nurse” and “perception of the target” were added to represent the impact of one’s perception on influence tactics chosen by the CNE/ nurse (agent) and the impact of perception on feedback given by the target. It was
hypothesized, based on doctoral course dialogue that perception plays an important role in impacting influence outcomes.

Coursework focusing on nursing theory and knowledge development led to the author’s understanding that graphic representations of the most widely used theories and models have a fluid appearance and a visual appeal. Grand theories and models, specifically those developed by Roy, Newman, and King (King, 1981; Newman, 1994, 2008; Roy, 2008; Roy & Andrews, 1999) were also reviewed to assess their compatibility with the mid range conceptualization of the Adams Influence Model. This review led to yet another restructuring of the AIM.

The AIM Iteration Four

The AIM Iteration Four was designed as an open system based on the work of the “father of systems theory,” Ludwig von Bertalanffy (1968) as well as subsequent systems work by King (1981). Clarity around this concept of open systems was essential in articulating the flow of the model along with its interactivity and the interrelationship of concepts. This is represented by the three outer rings of the AIM. These rings signify a fluid interrelationship between personal, interpersonal and social systems.

Content from prominent nursing theories including, Margaret Newman’s Health as Expanding Consciousness (Newman, 1994, 2008) and Sr. Callista Roy’s Adaptation Model (Roy, 2008; Roy & Andrews, 1999) were initially used to inform the multifaceted process of influence at the heart of the AIM. It was hypothesized that the tactics chosen and feedback given were part of an iterative and adaptive process while the perception of the target and perception of the agent was dependent on one’s relationships and lived experience. Further refinement led to the belief that the perception of the target and
perception of the agent was dependent on one’s lived experience. Action taken, the
tactics chosen and feedback given were identified as part of a reflective dialogue.

It is however, Imogene King’s Interacting Systems Theory and Theory of Goal
Attainment (King, 1981; Sieloff Evans, 1991) appeared to have the greatest congruence
with the concepts and structure within AIM Iteration IV. The assumptions, concepts and
relationships used within King’s conceptual framework of Interacting Systems and the
Theory of Goal Attainment, mirrored the concepts identified through literature reviews of
organizational psychology, organizational behavior, sociology, and to some extent
nursing that traditionally reported the incorporation of concepts related to interpersonal
influence and issue selling. The author conducted a detailed analysis of similarities and
differences between the AIM and King’s Conceptual Framework of Interacting Systems
and Theory of Goal Attainment (Adams, 2005). Conclusions from this analysis
suggested that while several concepts were shared, and influence may be a goal to be
attained, the AIM increased specificity surrounding the characteristics and process of
attaining influence (Adams, 2005).

The majority of concepts in the AIM Iteration Four while presented differently
were the same contextually as those seen in Iteration Three. This is represented within
Figure 2. The primary addition to the AIM Iteration Four was the inclusion of personal,
interpersonal and social systems as identified by von Bertalanffy (1968). These new
concepts, depicted as the outer rings within Figure 2, represented the inclusion of the
open systems concept. The dotted line representation of the rings signified the dynamic
and fluid nature of influence which is informed by experience and context. The
innermost ring represented the personal system whereby an individual has an impact on
this system. An example of this would likely best be explained by a concept like individual persistence and how that might impact achieving influence. The second ring represented the interpersonal system whereby a personal history between the agent and target may have an impact on achieving influence. The third ring represented the social system, and would be inclusive of issues like organizational culture and how they might impact achieving influence.

Figure 2. Adams Influence Model – Iteration Four (April 2007)
This redesigned graphic representation of the AIM followed an intense review of nursing theory development. The AIM Iteration Four design was represented conceptually as a camera lens; signifying perspective surrounding a particular “snapshot” moment in time suggesting that time played some role in influence. At the core of the AIM, remained single issue influence whereby an influence agent, (i.e. CNE) has a perception of her/his influence target’s influence factors. The CNE chooses influence tactics based upon this perception and context. Likewise the influence target has a perception of the influence agent’s influence factors. The target’s perception of the influence agent coupled with the tactics chosen will then lead the influence target to provide feedback, either positive (influence is achieved) or negative (influence is not achieved). The influence agent, then has additional knowledge based upon this experience and if influence is not achieved, the process can begin again and different influence tactics can be chosen.

Moving out from the core, the five influence factors (knowledge/competence, authority, status, interpersonal attributes and situational & environmental awareness) are possessed by both the influence agent and influence target. These influence factors and their subcomponent influence attributes are variable given each individual issue. This means that the influence agent and influence target will possess a different degree of influence factors and influence attributes given each singular issue. Thus it is necessary to evaluate tactics and strategies with each individual issue as achieving influence will require a continued titration of influence factors based on perception and feedback.

The AIM Iteration Five

After a year of reflection, continued literature review, discussions with nurse executives who reviewed the AIM, and experiences within acute care executive teams
both in the United States and abroad, minor alterations were made to the AIM. These revised concepts, listed in Table 5, provided improved clarification and a more accurate representation of influence factors, influence attributes or concepts identified within the AIM.

Table 5

<table>
<thead>
<tr>
<th>Old Concept</th>
<th>New Concept</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge/ Competence</td>
<td>Knowledge Based</td>
<td>Knowledge as the foundation of competence.</td>
</tr>
<tr>
<td></td>
<td>Competence</td>
<td></td>
</tr>
<tr>
<td>Tactics</td>
<td>Tactics/ Interventions</td>
<td>The concept interventions is more suited for the practice of nursing.</td>
</tr>
<tr>
<td>Interpersonal Attributes</td>
<td>Communication</td>
<td>More accurately describes the Influence Factor and sub-components (attributes).</td>
</tr>
<tr>
<td></td>
<td>Traits</td>
<td></td>
</tr>
<tr>
<td>Communication Skills</td>
<td>Message Articulation</td>
<td>More accurately describes the attribute.</td>
</tr>
<tr>
<td>Situational and</td>
<td>Time and Timing</td>
<td>The concept of perception will be addressed elsewhere in the AIM, thus Time</td>
</tr>
<tr>
<td>Environmental Awareness</td>
<td></td>
<td>and Timing were identified as Influence Factors.</td>
</tr>
<tr>
<td>Perception of Target</td>
<td>Perception(s)</td>
<td>All perceptions address in a single concept, perception of self, others,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>organization, environment. All lead to the selection/ identification of tactics/interventions.</td>
</tr>
<tr>
<td>Perception of Nurse</td>
<td>Perception(s)</td>
<td>All perceptions address in a single concept, perception of self, other(s),</td>
</tr>
<tr>
<td></td>
<td></td>
<td>organization, environment. All lead to the nature of feedback.</td>
</tr>
</tbody>
</table>

Model Description

The AIM Iteration Five, represented in Figure 3, remains an open-systems model based on the work of von Bertalanffy (1968) and King (1981). The importance of the
open-systems model is simply representative of the interdependencies of the personal system, interpersonal system and social system as explained in Table 5. The dotted line circles at the outside of the model in Figure 3 depict these permeable systems where occurrences within each system can and does impact each of the other systems.

While the personal, interpersonal and social systems interrelate within the AIM Iteration Five, the representation provided is designed to define interpersonal influence within a two person dyad for any single issue, for example a single issue may be the selection of a clinical information system. A dyad could include the Agent (Chief Nurse Executive) and a Target of Influence (Patient Care Services Staff Member). As human beings, the Agent (CNE) and the Target of Influence each possess qualities, characteristics and skills that can be used in the influence process. These qualities, characteristics and skills are also known as influence factors. More specifically, influence factors are: knowledge based competence, authority, status, communication traits, and time & timing. Together, these influence factors form the fourth concentric circle in the model. Influence factors are variable, meaning that once can possess more or less of any single or multiple influence factors given any one issue. An example of this would include, a CNE likely having more knowledge based competence and/or authority over the issue staff nurse education budgeting as compared with CNE knowledge based competence or authority over Municipal Automobile Maintenance Schedules.

Influence factors also contain subcategories or influence attributes. For example, the influence factor - authority is comprised of the influence attributes - accountability and responsibility. Figure 3 represents the AIM Iteration Five and Table 6 represents the
associated conceptual and operational definitions of the AIM’s *influence factors* and associated *influence attributes*.

Figure 3. Adams Influence Model – Iteration Five (August 2007)
Table 6

**Operational Definitions of the Adams Influence Model - Iteration Five (August 2007)**

<table>
<thead>
<tr>
<th>Influence Factors</th>
<th>Operational Definition</th>
<th>Influence Attributes</th>
<th>Operational Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge Based Competence</td>
<td>The quality of being adequately or well qualified intellectually so as to meet or exceed standards of performance (competence, n.d.)</td>
<td>Empirical Knowledge</td>
<td>The application of theories of science. Factual knowledge of nursing, the scientific body of nursing knowledge (Carper, 1978).</td>
</tr>
<tr>
<td>Personal Knowledge</td>
<td>Providing means to become more aware of culture, customs, beliefs and emotions (Carper, 1978).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aesthetic Knowledge</td>
<td>Envisioning desired outcomes in order to respond with appropriate action. It is creative open, empathetic and holistic (Carper, 1978).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethical Knowledge</td>
<td>The capacity to make choices within situations to make moral judgments. Ethical knowing is expressed in Codes, Standards and Ethical Frameworks (Carper, 1978).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sociopolitical Knowledge</td>
<td>Some sociopolitical areas that affect the health of the population are class structure, poverty, sexism, racism, etc. (White, 1995).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influence Factors</td>
<td>Operational Definition</td>
<td>Influence Attributes</td>
<td>Operational Definition</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------</td>
<td>----------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Authority</td>
<td>The right to take actions or responsibility (Hicks, 1972)</td>
<td>Accountability</td>
<td>the state of being liable, or answerable (accountability, n.d.)</td>
</tr>
<tr>
<td>Status</td>
<td>Having high standing or prestige (status, n.d.)</td>
<td>Responsibility</td>
<td>the social force that binds you to the courses of action</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hierarchical Position</td>
<td>demanded by that force (responsibility, n.d.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>an organized body of officials in successive ranks or orders (hierarchy, n.d.; position, n.d.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Key Relationships</td>
<td>an emotional or other connection between people</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(relationship, n.d.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reputation</td>
<td>a favorable and publicly recognized name or standing for</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>merit, achievement, reliability (reputation, n.d.)</td>
</tr>
</tbody>
</table>

*Table continues*
<table>
<thead>
<tr>
<th>Influence Factors</th>
<th>Operational Definition</th>
<th>Influence Attributes</th>
<th>Operational Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication Traits</td>
<td>the proficiency or dexterity with which one relates or interacts with individuals</td>
<td>Message Articulation</td>
<td>the shape or manner in which things come together and a connection is made (articulation, n.d.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emotional Involvement</td>
<td>to engage the interests or emotions or commitment of (involvement, n.d.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Persistence</td>
<td>the act of persevering; continuing or repeating behavior (persistence, n.d.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Confidence</td>
<td>belief in oneself and one's powers or abilities (confidence, n.d.)</td>
</tr>
<tr>
<td>Physical Appeal</td>
<td>the ability to attract, interest, amuse, or stimulate the mind or emotions based upon appearance (appeal, n.d.)</td>
<td>Amount of time to sell the issue</td>
<td>a limited period or interval, as between two successive events (time, n.d.)</td>
</tr>
<tr>
<td>Use of Time and Timing</td>
<td>Timing to deliver the issue</td>
<td>the selecting of the best time or speed for doing something in order to achieve the desired or maximum result (timing, n.d.)</td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>A healthcare professional dedicated to meaning-making and influencing patient integration, and humanization in the person-environment situation of which health, illness, and health-within-illness are possibilities (Willis, Grace, &amp; Roy, 2008).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target of Influence</td>
<td>One to be influenced or changed by an individual, action or event (target, n.d.).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interventions/Tactics</td>
<td>Care or measures provided to improve a situation or outcome (intervention, n.d.).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feedback</td>
<td>a reaction or response to a particular process or activity (feedback, n.d.).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perception(s)</td>
<td>a unified awareness derived from sensory processes (perception, n.d.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perception of Self</td>
<td>a single unified awareness derived from sensory processes focused on self (perception, n.d.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perception of Other(s)</td>
<td>a single unified awareness derived from sensory processes focused on others (perception, n.d.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perception of Organization</td>
<td>a single unified awareness derived from sensory processes focused on organization (perception, n.d.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perception of Environment</td>
<td>a single unified awareness derived from sensory processes focused on environment (perception, n.d.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OPERATIONAL DEFINITIONS WITHIN AIM</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influence is best defined as the ability of an individual (agent) to sway or affect another person or group (target) based on authority, status, knowledge based competence, communication traits and use of time and timing (influence, n.d.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal System</th>
</tr>
</thead>
<tbody>
<tr>
<td>An individual utilizing information. (King, 1981)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interpersonal System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groups of individuals including dyads, triads as well as groups whereas complexity and variability increase with its size (King, 1981).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social System</th>
</tr>
</thead>
<tbody>
<tr>
<td>An organized boundary system of social roles, behaviors and practices to maintain values and the mechanisms to regulate the practices and rules (King, 1981).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>the cumulative of being influential over several single issues</td>
</tr>
</tbody>
</table>
The influence attributes and thus influence factors are modifiable and exist in varying degrees within each Agent and the Target of Influence. They can vary based upon the issue as well. While there is no set formula, it is the titration of these influence factors and influence attributes that lead one to achieve influence on any single issue.

Single issue influence was chosen because an individual can possess varying levels of influence around any given issue. For example, a CNE may be very influential when speaking to the issue of nurse staffing ratios with their congressional representative, whereas s/he is not likely to be as influential when speaking to the issue of deep sea fishing in the North Atlantic.

Single issue influence is an important concept because the concept of influence is often used incorrectly as a synonym to the concept of power. While influence and power are related concepts, within the AIM, they are conceptualized as different. Power within the conceptualization of the AIM is defined as the cumulative of being influential over several single issues. Using the previous example, a CNE may be powerful within healthcare because of her/his influence with different persons across multiple issues, from nurse staffing ratios to work environments to information technology to care delivery practices. This same CNE/agent is likely not powerful within the commercial fishing arena.

At the core of the AIM is a pattern based on a singular issue which involves the concepts perception, tactics/ interventions and feedback. This pattern includes;

1. The Nurse (Influence Agent) perceiving the Target’s collective influence factors
   a) Knowledge Based Competence  
   b) Authority  
   c) Status  
   d) Communication Traits  
   e) Time and Timing
2. The Nurse (Influence Agent) choosing and using tactics/ interventions to influence the Target

   a) Pressure  f) Ingratiating  
   b) Upward Appeal  g) Consultation  
   c) Exchange  h) Rational Persuasion  
   d) Inspirational Appeal  i) Collaboration  
   e) Coalition  j) Legitimizing  
   k) Apprising

3. The Target perceiving the Nurse (Influence Agent’s) collective influence factors

   a) Knowledge Based Competence  d) Communication Traits  
   b) Authority  e) Time and Timing  
   c) Status

4. The Target giving feedback to Nurse (Influence Agent).

The AIM was designed to represent a camera lens. This was purposeful as the concept of interpersonal influence is a snapshot with the focus being on the four step core. If influence is not achieved with the first attempt, each new attempt is dependent on both the target and agent’s reflective interactions. This is a sequential as opposed to iterative pattern as with each successive attempt perceptions, time and knowledge change while different tactics may be chosen and new feedback given. If influence is achieved, the pattern ends for this particular issue.
CHAPTER FOUR - RESEARCH METHODOLOGY

Introduction

The recent Institute of Medicine Report, Keeping Patients Safe – Transforming the Work Environment of Nurses, suggests that organizational nursing leadership is vital for nursing success and positive patient outcomes (Institute of Medicine, 2004). However, this report and virtually all other nursing literature, fails to define how the Chief Nurse Executive (CNE) and her/his interpersonal influence with fellow executive team members has an impact on these outcomes. Based on a synthesis of the literature, the phenomenon influence is best defined as the ability of an individual (agent) to sway or affect another person or group (target) based on authority, status, knowledge based competence, communication traits and use of time and timing. Influence is often a key determinant in motivating, securing support and resources and in affecting decision making (Yukl & Falbe, 1990). It is important to note that influence is issue based, meaning that the agent and target each possess more or less of an influence factor given any single issue. Gaps in current literature dictate a need for exploration into the disciplinary influence possessed, used and valued in nurse executive practice.

Purpose and Questions

The primary purpose of this study was to validate and/or refine the Adams Influence Model as represented in Figure 3 following secondary analysis of qualitative data collected as part of a large medical center’s staff evaluation of the Professional Practice Environment. Within this context, the following questions were asked:

1. What influence concepts, as defined by the AIM, are identified by a nursing and multidisciplinary professional staff as necessary for the CNE and patient care
services executive team seeking to maximize the professional practice environment?

2. What are the influence factors and influence attributes identified most frequently by multidisciplinary professional staff responding to the Professional Practice Environment survey?

3. How does data from this analysis support or refute the factors, attributes and related definitions as described within the AIM?

Methodology & Data Analysis

The study used directed qualitative content analysis as described by Hsieh and Shannon (2005) to validate and refine influence factors and influence attributes of the AIM toward answering each of the three research questions. Directed content analysis usually starts with a theory or relevant research findings and uses pre-existing concepts from the particular theory or research findings, to code or structure results. The themes derived as a result of directed content analysis are usually used to validate or extend a conceptual framework or theory (Zhang, 2006). This current study used the AIM and its preexisting concepts as the framework for data coding.

The definition of content analysis has evolved over time but has come to mean a rigorous form of qualitative and statistical examination. A rigorous statistical content analysis is valuable in that it examines trends and patterns where as the qualitative analysis helps with the identification of existing and developing themes. As the majority of information humans receive is second hand, it is an ongoing struggle to manage the huge volume. Thus, we generally rely on some authority to review and synopsize it (Carney, 1972). Content analysis using a directed approach is guided by a more
structured process than traditional content analysis (Hickey & Kipping, 1996). According to Krippendorff (2004) “Content analysis is potentially one of the most important research techniques in the social sciences (p. xii).” Content analysis creates a purity of data in that neither the sender nor the receiver of the message is aware that it is being analyzed. There is little risk in that the anticipation of measurement will confound the data (Weber, 1990).

Data analysis of nursing and other professional staff responses to the qualitative section of the Professional Practice Environment survey was evaluated and coded based upon the previously identified concepts and definitions of the AIM. While a thorough review of the literature and consultation by nursing leaders led to the development of the Adams Influence Model, this theoretical representation served only to guide the analysis to permit further inquiry in gathering a broad understanding of influence factors and associated influence attributes identified by staff as being visible in CNE practice.

**Rigor**

Rigor is traditionally a challenge in qualitative research (Sandelowski, 1993). Rigor was deeply engrained within this study. Qualitative content analysis research methods were used because of the lack of research and literature surrounding influence within the CNE population. Significant research has been completed on Influence Tactics, these findings have been integrated as one component of the AIM (Dutton & Ashford, 1993; French & Raven, 1959; Katz & Kahn, 1966; Kipnis, 1976; Kipnis & Schmidt, 1988; Piderit & Ashford, 2003; Yukl & Falbe, 1990; Yukl & Siefert, 2002). However, the populations previously investigated were predominantly males working
outside of the healthcare setting. This study specifically focused on the concepts of *influence factors* and *influence attributes* as opposed to *influence tactics*.

An experienced qualitative research team was available and reviewed data analysis and interpretations during the analysis phase of the study. An audit trail was kept to identify the development of coded themes. This study followed research standards and criteria for evaluating rigor in qualitative studies including credibility, fittingness and auditability as suggested by Beck (1993), Guba & Lincoln (1981) and Sandelowski (1986), these criteria as used within this study are described in greater detail to follow.

*Credibility*

Credibility in qualitative research refers to the vividness and detailed description of the phenomenon (Beck, 1993). In order to assure the vividness and description of the phenomenon, influence, the researcher kept in depth notes to thoroughly describe the categorization of data. Representative quotes were used to support the categorization of data. The researcher worked with an experienced team so as to guard against researcher bias and the incorrect inclusion or exclusion of evidence.

*Fittingness*

Fittingness refers to how well the hypothesis fits contexts other than the one for which they were generated (Guba & Lincoln, 1981). As part of future research, the researcher aims to develop an overall “profile” of the CNE, whereas one can identify and measure opportunity for CNE success through a combination of *influence attributes* and a “report card”. The findings of the study are reported clearly. The research team identified variation in responses so as not to “over-similarize” responses and to assure
that the results closely aligned with the data that was generated across the fullest range of responses.

Auditability

Auditability is the ability of another investigator to follow the decision or audit trail (Guba & Lincoln, 1981). The investigator kept an audit trail of all decisions made. Within this study, the researcher kept thorough notes both electronically and in hard copy describing in detail the description of strategies, including, research approach, methods, data analysis strategies and drawing of conclusions. The researcher worked with a research team to identify codes, make comparisons among codes, and evaluate codes for fit within the AIM. The goal of auditability was to permit future researchers to replicate, duplicate and/or build on the work of this study.

Data Source

The data used for this study were obtained from qualitative responses written by professional healthcare staff across multiple clinical disciplines responding to a survey reflective of the professional practice environment. A secondary directed qualitative analysis of these responses was performed. That is a reanalysis of preexisting data by the researcher removed from the original data collection analyzed the data for purposes of addressing new questions not addressed in the original research (Turner, 1997). The professional groups that provided the original data source for this secondary analysis included Chaplaincy, Nursing, Occupational Therapy, Physical Therapy, Respiratory Therapy, Social Work and Speech & Language. These data were included as part of a larger survey, Survey of the Professional Practice Environment (SPPE) that provided data on staff satisfaction with the practice environment.
The first SPPE survey tool, administered to staff in 1999, was based on the hospital’s Professional Practice Model (MGH Patient Care Services, 2006), which is a framework used to guide professional practice valuing interdisciplinary collaboration in the care of patients and families (Ives Erickson, 1996). The survey was developed to provide an administrative report card for the CNE and executive leadership toward continuous improvement of the Patient Care Services work environment (MGH Patient Care Services, 2006).

The survey, has undergone minor revisions since its inception and has been distributed on a regular basis (18-24 months) to all professional staff, initially via US mail. In 2006, an online version of the survey was developed and presented as an option for staff to provide data. A mail survey was also available for staff who chose not use the use the online survey. A random unique identifier was generated by the Harvard Institute for Health Policy (the external group administering and analyzing data) to assure anonymity and restrict each participant to one completed survey. The surveys were collected, analyzed and reports were generated by the Harvard Institute for Health Policy (IHP). The MGH Knight Center for Clinical and Professional Development and later the MGH Munn Center for Nursing Research worked with IHP to prepare final reports. Survey results were disseminated through several presentations internal to MGH and publications (Ives Erickson et al., 2004; Ives Erickson et al., 2008).

Study Sample

The Survey of the Professional Practice Environment (SPPE) is a four part survey. All of PCS direct care providers were eligible to participate in the survey. The number of eligible participants totaled 3014 persons. Section I of the SPPE contains
demographic information. Section II, also referred to as the PPE, consists of a forty item survey with questions items spanning eight subscales determined to be important measures of clinician satisfaction. These subscales are represented in Appendix F (MGH Patient Care Services, 2006). The subscales have been psychometrically validated and judged sufficiently reliable for use as independent measures (Ives Erickson et al., 2004; MGH Patient Care Services, 2006). Section III of the SPPE, consists of staff rankings of common patient problems and staff preparedness to manage problems and perceived adequacy of resources to deal with the problems. Section IV data included open-ended responses as part of the SPPE. The data from section IV was used as the data source for this study. Participants from across all areas of Patient Care Services were free to add there thoughts to a section of the survey called,

“YOUR COMMENTS: Please feel free to write any comments you have in regards to any of the topics in this survey as well as topics not covered in this survey that pertain to the professional practice environment.”

40% of the 2006 SPPE survey respondents wrote some comments. Respondents provided a total of 726 qualitative comments, 509 responses (70%) came from nursing staff and 217 responses (30%) came from non-nurse professional staff, including Chaplaincy, Occupational Therapy, Physical Therapy, Respiratory Therapy, Social Work and Speech & Language. Comments ranged in length from one word to 5 type written pages.

In 2006, at least one section of the SPPE (the PPE) was completed by 1837 persons across disciplines yielding an overall 61% response rate. Respondents to the SPPE were primarily female (93%) with a mean age of 41 years old. The majority of respondents worked full time (60%), averaging 16 years in their current profession.
Additionally, more than three quarters of respondents reported their highest educational preparation as being at the Bachelors Degree or higher (MGH Patient Care Services, 2006).

**Study Procedure**

The specific intent of this study was to validate and refine the Adams Influence Model. All data was coded and categorized according to the concepts identified in the AIM as listed in Table 6 using directed content analysis as described by Hsieh & Shannon (2005). Thus, the researcher began by defining and isolating each influence factor and influence attribute concept used in the AIM as depicted in Table 6. The researcher reviewed survey comments as mentioned previously, making either explicit or implicit reference to identifiable AIM influence concepts and operational definitions. Then, the researcher coded the concepts of influence for each response by participant. These coded concepts used the operational definitions of the AIM as described in Chapter 3. When codes identified did not fit within the AIM, concepts were identified, isolated, and analyzed for purposes of revising the AIM.

Each response provided in the data set was scored and reported in a table highlighting responses from nurses and non-nurses. The responses from nurses and non-nurses were then compared to identify differences in how nurses and non-nurses identify the concepts of CNE influence within this data set. These two data sets of responses were then merged to represent the data in aggregate. Each individual respondent comment was reviewed in its entirety a minimum of three times. Upon completion of the review, tabulated results were reviewed with three doctoral prepared experts experienced in qualitative analysis methodology. The researcher additionally sought data analysis
validation from an external doctorally prepared nurse researcher with qualitative methods expertise.

Individual comments potentially contained multiple identifiable *influence factors* or *influence attributes*, however a single *influence factor* or *influence attribute* was only scored once per individual comment even if the concept was identified and met the operational definition multiple times. This single scoring was chosen to limit the number of single concepts identified by one respondent. In the following example, the concept of responsibility was identified three times, one time explicitly and two time contextually. For purposes of this study, “responsibility” was only scored once within this unique response so as to limit repeat concepts from a single respondent.

“I feel that my work environment has no accountability. Staff does not take responsibility for their assignments and follow through to provide competent care to our patient population. Orders are not followed and vital signs and assessments are not done as dictated per policy. Staff does not have adequate information about their patients when providing care and do not pass on appropriate or adequate report at the end of their shift. Our nurse manager has all wonderful new ideas she wants to role out on our unit; but there are so many issues we have with just our fundamentals of providing care that I think we need to reeducate and set standards and expectations of care for our patients now before we implement new care methods.”

Several matrices were constructed and profile and proximity matrices were developed to organize the demographic, departmental/organizational and descriptive data (Bernard, 2000). An additional matrix which included representative comments was developed to provide a clear description of themes identified in the coding process (Miles & Huberman, 1994; Sandelowski, 2000). An audit trail history notebook was electronically maintained by the primary investigator an example of which can be found in Appendix H.
The initial data review identified thematic concepts of influence within each respondent’s comments. A hard copy printout of each response was numbered and those concepts that were identified as coordinated with the AIM Iteration Five were scored as such, and example of this can be found in Appendix G – Example of Qualitative Data Coding. Simultaneously, each respondent comment was coded. This code was entered into an individual cell within a single Microsoft Excel spreadsheet column. The influence factors and corresponding influence attributes of the Adams Influence Model (AIM) were listed across consecutive rows of the same Microsoft Excel spreadsheet, and example can be seen in Figure 4.

Figure 4. Review One Example Spreadsheet - Initial AIM Validation Tool

<table>
<thead>
<tr>
<th>Row</th>
<th>Knowledge Based Consensus</th>
<th>Author</th>
<th>Authority</th>
<th>Status</th>
<th>Communication Traits</th>
<th>Use of Time and Title</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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</tbody>
</table>

Respondent comments with thematic influence concepts that were not identified as part of the AIM Iteration Five were highlighted within the Microsoft Excel Spreadsheet for further review. Additionally, notes were added into a cell within the Microsoft Excel Spreadsheet. The highlighted concepts (darker gray cells along the second row of Figure 5) helped identify new influence attributes including, access to resources, leadership support, colleague support, informal position, presence, and increased specificity in the physical appeal category to include physical appeal.
environment and physical appeal self. These new influence attributes did not fit into the preexisting categories of the AIM. The rows highlighted in (Figure 5 rows 57 and 60) helped to identify the point at which a new concept was identified. In this example, the Row 57 identified the point at which leadership support was first recognized as an influence attribute. The Row 60 identified a researcher note questioning whether Growth as a Professional should be scored as aesthetic knowledge. The highlighted rows signified opportunity for reevaluation of the entire data set based on these new notes.

Figure 5. Review Two Example Spreadsheet - Updated AIM Validation Tool

Upon completion of Review Two, definitions of and categorization of influence attributes were reevaluated. Newly identified concepts were named, defined, added to the matrix and analyzed for potential inclusion in the AIM. The concept access to resources was accepted as an influence attribute of the influence factor – authority.

Access to resources defined as: the ability, right, or permission to approach, enter, speak with, or use a source of supply, support, or aid (access, n.d.; resources, n.d.) included concepts pertaining to access to information, access to human capital, and access to physical tools. The concepts of leadership support and colleague support originally
listed as influence attribute of authority were combined and identified as the single concept key supportive relationships. The key supportive relationships influence attribute was identified as being most fitting with the influence factor - status. Additionally the concept informal position was identified as an attribute of the influence factor - status. Informal position, defined as unconventional status or standing, without formality (informal, n.d.; position, n.d.), identified those with non-hierarchical status such as “cliques,” staff designated to lead committees, or in some instances other care providers without line authority (physicians). The concept presence was accepted and added as an influence attribute of the influence factor – communication traits. Presence was defined as a quality of self assuredness and effectiveness, or command of attention (presence, n.d.).

The concept of physical appeal was separated into two distinct influence attributes those being physical appeal environment and physical appeal self. The premise for this realignment of concepts was based on the data that identified physical environment as important to respondents to the survey. Understandably, this finding led the researcher to redefine operational definitions and hypothesize that influence may be more readily achieved when delivering a message in a physically appealing environment. The concept of physical appeal self was initially conceptualized as part of the AIM and while the concept was seldom identified within survey responses in this study, the concept did exist within responses. An example of physical appeal self would include,

“Staff’s personal appearance. Example, long hair and unkempt uniforms is not always appropriate.” #440 Nursing Review Three involved identifying the refined influence concepts within each comment. Each influence attribute and influence factor was scored within a Microsoft
Excel AIM Validation Tool. An example of the Final AIM Validation Tool can be found in Appendix H. Each influence concept included as part of the Final AIM Validation Tool was identified within the comments analyzed. The influence attribute – physical appeal self was the least identified influence concept (n=4) and influence attribute – key supportive relationships was the most identified concept (n=341).

Contextual Use of the Tool and Data Coding/ Scoring

An important note, the focus of this study was to identify concepts existent or necessary to enact influence, therefore the contextual positive or negative nature of the responses is irrelevant in this analysis. In many instances, respondents identified the presence of an influence attribute “I am proud and very fortunate to work in an institution that is professional…” likewise, respondents also identified when a concept may have been absent or lacking “Staff does not take responsibility”. In each case the concept was identified as necessary to enact influence and thus coded/ scored equally.

As a point of transparency, during a separate data analysis conducted in 2006, the positive/ negative nature of commentary was evaluated (Jones, 2006). This separate review aimed at understanding workplace satisfaction for health care professionals identified that the vast majority of the overall responses were qualified as being positive in nature (Jones, 2006). Responses identified as “positive” included items such as “I feel that over the last year, things have improved…” and “I am very happy with my job.” Conversely, only 19% of the overall comments were identified as reflective of being negative or workplace dissatisfaction. Responses identified as being “negative” included “Morale on this unit … so low this past year since the arrival of new management…” and “…Manager changes policies and favors other staff members creating an unfair work
environment.” Several of the examples used in this study appeared to be negative in nature. The overwhelmingly positive nature of responses is important to note so as to not misrepresent the data used in this study.

Additionally, to further protect confidentiality it is important to note that the original PPE tool was designed to give data back to patient care services leadership. Each respondent to the survey had an option to limit disclosure of their comments. Each respondent writing comments responded to the yes or no question, “Do you want your comments released?” Any comments with a “no” response while included in the data analysis for this study, were not used in the content/ textural exemplars as part of this study. Comments requested as not to be released do however appear in the tabulations for nursing, non-nursing, and aggregate totals. Commentary requesting limited disclosure represented 15% of nursing comments, 15% of non-nursing comments and thus 15% of total number of comments.

Summary

This chapter described the methods and process that were utilized in this study toward the validation of the Adams Influence Model (AIM). The study used directed content analysis to categorize specific references to CNE influence as described by professional staff responses to a 2006 survey evaluating the clinician professional practice environment in the acute care setting. The process which included a thorough review by content and qualitative methods experts consisted of a three step evaluation of AIM concepts and operational definitions toward the validation and refinement of the AIM when exposed a pre-existing data set.
CHAPTER FIVE – FINDINGS

Introduction

The primary purpose of this study was to validate and/or refine the literature guided Adams Influence Model as represented in Figure 3, following secondary analysis of qualitative data collected as part of a large medical center’s evaluation of the Professional Practice Environment. Within this context, the following questions were asked:

1. What influence concepts, as defined by the AIM, are identified by a nursing and multidisciplinary professional staff as necessary for the CNE and patient care services executive team seeking to maximize the professional practice environment?

2. What are the influence factors and influence attributes identified most frequently by multidisciplinary professional staff responding to the Professional Practice Environment survey?

3. How does data from this analysis support or refute the factors, attributes and related definitions as described within the AIM?

Influence Factors Findings Summary

Influence factors are qualities, characteristics and skills that can be used by an individual in the influence process, these include the conceptual categories: knowledge based competence, authority, status, communication traits, use of time and timing. Influence factors are comprised of multiple subcomponent influence attributes. The following figures and tables highlight the number of influence factor identified within staff survey responses that reflect staff perceptions of the CNE and patient care executive
team seeking to maximize the Professional Practice Environment. Quantified totals within Tables 8 - 10 and Figures 6 - 8 represent staff responses in the SPPE data set discussed in Chapter 4. These concepts were identified and grouped by the researcher within influence factor categories. These tables represent the responses by nurse and non-nurse participant as reported in this data set. Specific examples of representative influence factor data is found both within the influence attributes section to follow. 

Influence Factors Identified By Nursing

Forty percent of all SPPE respondents wrote some comments in Section IV of the survey. These open ended qualitative responses were used as the data set for this study. Of that 40%, nursing responses represented 1534 concepts or 80% of the total number of concepts identified within this data set. The influence factors, authority, status, and communication traits represented more that 25% of the nurse staff responses (27%, 27% and 26% respectively) within this study and are represented in Figure 6 and Table 7. These findings are supportive of the operational definitions of the AIM and suggested that nurses readily identified the concepts of Authority, Status and Communication traits as valuable and necessary for the CNE and patient care executive team to use when seeking to influence and maximize the professional practice environment. The influence factor - knowledge based competence was represented within 10% of the concepts identified while the influence factor - use of time and timing represented 6% of the concepts identified.
Of the 1534 qualitative responses by nurses 68 could not be categorized and were classified as N/A. These concepts included language not pertinent to the concept of influence or the AIM. They included comments about the survey overall, or the experience of completing the survey. Four percent of “Nursing” responses were classified as N/A. Examples of comments classified as N/A include,

“Most areas of this survey do not apply/are N/A to our area of practice.”

“Many of the questions are difficult to give one answer to because you're trying to generalize many different situations. I think it would be more beneficial to know ”why” I answered the way I did as well as the other people taking the survey.”

Figure 6. Influence Factors From Data Set Identified By Nursing
Table 7

Influence Factors From Data Set Identified By Nursing

<table>
<thead>
<tr>
<th>Respondent Group</th>
<th>AIM – Influence Factor</th>
<th>Number of Concepts Identified</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>Status</td>
<td>416</td>
<td>27%</td>
</tr>
<tr>
<td>Nursing</td>
<td>Authority</td>
<td>412</td>
<td>27%</td>
</tr>
<tr>
<td>Nursing</td>
<td>Communication Traits</td>
<td>392</td>
<td>26%</td>
</tr>
<tr>
<td>Nursing</td>
<td>Knowledge Based Competence</td>
<td>157</td>
<td>10%</td>
</tr>
<tr>
<td>Nursing</td>
<td>Use of Time and Timing</td>
<td>89</td>
<td>6%</td>
</tr>
<tr>
<td>Nursing</td>
<td>N/A</td>
<td>68</td>
<td>4%</td>
</tr>
<tr>
<td>Nursing</td>
<td>TOTAL</td>
<td>1534</td>
<td>100%</td>
</tr>
</tbody>
</table>

Influence Factors Identified By Non-Nursing

Responses from Non-Nursing departments including, Chaplaincy, Occupational Therapy, Physical Therapy, Respiratory Therapy, Social Work and Speech and Language represented 376 concepts or 20% of the total number of concepts identified when subjected to directed content analysis. The influence factors, status, authority, and communication traits represented more than 25% of the concepts identified within non-nurse patient care staff responses (29%, 28% and 28% respectively) as identified in Figure 7 and Table 8. The influence factors - knowledge based competence and use of time and timing each were represented within 6% of the non-nurse responses. The percentage of use of time and timing was similar to that of nurse respondents while the percentage of knowledge based competence responses were slightly less 6% non-nurse responses as opposed to 10% nurse responses.

Of the 376 qualitative concept responses identified non-nurses 12 could not be categorized and were classified as N/A. These concepts included items not pertinent to the concept of influence or the AIM such as comments about the survey tool, or the experience of completing the survey. Three percent of “Non-Nursing” responses were classified as N/A. An example of an N/A response is included:
“When filling out section A - I felt certain areas/questions should have been answered with a "sometimes" answer vs. a "disagree/agree" response.”

“Some of the issues listed do not apply to this department so I think a column for n/a would have been helpful.”

Figure 7. Influence Factors From Data Set Identified By Non-Nursing Patient Care Personnel

Table 8:

Influence Factors From Data Set Identified By Non-Nursing Patient Care Personnel

<table>
<thead>
<tr>
<th>Respondent Group</th>
<th>AIM – Influence Factor</th>
<th>Number of Concepts Identified</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-nursing</td>
<td>Status</td>
<td>109</td>
<td>29%</td>
</tr>
<tr>
<td>Non-nursing</td>
<td>Communication Traits</td>
<td>107</td>
<td>28%</td>
</tr>
<tr>
<td>Non-nursing</td>
<td>Authority</td>
<td>104</td>
<td>28%</td>
</tr>
<tr>
<td>Non-nursing</td>
<td>Knowledge Based Competence</td>
<td>23</td>
<td>6%</td>
</tr>
<tr>
<td>Non-nursing</td>
<td>Use of Time and Timing</td>
<td>21</td>
<td>6%</td>
</tr>
<tr>
<td>Non-nursing</td>
<td>N/A</td>
<td>12</td>
<td>3%</td>
</tr>
<tr>
<td>Non-nursing</td>
<td>TOTAL</td>
<td>376</td>
<td>100%</td>
</tr>
</tbody>
</table>
Influence Factors From Data Set Identified By Nurses and Non-Nurses in Aggregate

The influence factors - authority, status, and communication traits were identified more that 25% of the aggregate patient care staff responses (28%, 28% and 26% respectively). Concepts of the influence factor - knowledge based competence were identified within 180 responses (9%) with use of time and timing being identified within 6% of the responses.

Of the 1910 qualitative concepts identified in aggregate, 80 responses could not be categorized within the AIM and were classified as N/A. These concepts included items not pertinent to the concept of influence or the AIM such as comments about the survey tool, or the experience of completing the survey. Four percent of “Non-Nursing” responses were classified as N/A.

Figure 8. Influence Factors From Data Set Identified By Nurses and Non-Nursing Patient Care Personnel in Aggregate
Table 9:

Influence Factors From Data Set Identified By Nurses and Non-Nursing Patient Care Personnel in Aggregate

<table>
<thead>
<tr>
<th>Respondent Group</th>
<th>AIM - Influence Factor</th>
<th>Number of Concepts Identified</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggregate</td>
<td>Status</td>
<td>525</td>
<td>28%</td>
</tr>
<tr>
<td>Aggregate</td>
<td>Authority</td>
<td>516</td>
<td>27%</td>
</tr>
<tr>
<td>Aggregate</td>
<td>Communication Traits</td>
<td>499</td>
<td>26%</td>
</tr>
<tr>
<td>Aggregate</td>
<td>Knowledge Based Competence</td>
<td>180</td>
<td>9%</td>
</tr>
<tr>
<td>Aggregate</td>
<td>Use of Time and Timing</td>
<td>110</td>
<td>6%</td>
</tr>
<tr>
<td>Aggregate</td>
<td>N/A</td>
<td>80</td>
<td>4%</td>
</tr>
<tr>
<td>Aggregate</td>
<td>TOTAL</td>
<td>1910</td>
<td>100%</td>
</tr>
</tbody>
</table>

Figure 9. Percent of Influence Factor Concepts Identified by Nurse, Non-Nurses and in Aggregate

Figure 9 represents a comparison of influence factors by percentage of concept responses as identified by the nurse, non-nurse and in the aggregate. Concepts representative of status, authority and communication traits were overwhelmingly the most frequently identified by each respondent category. Concepts within these influence
factor areas were each identified as more than 25% of the total responses within the nurse, non-nurse and aggregate categories. Concepts reflecting knowledge based competence, were identified forth most with a slight (4%) variance between nurse and non-nurse knowledge based competence responses. This 4% difference between nurses and non-nurses is the largest within any influence factor. Concepts representative of use of time and timing were identified least frequently or 6% of the time within each of the respondent categories.

Influence Attributes Findings Summary

Influence attributes are the subcomponent categories of the AIM influence factors as represented in Figure 3 and Table 6. Tables 10 - 14 represent participant responses as grouped by influence attribute. Concept responses were further isolated and categorized by nurse and non-nurse respondent as well as in aggregate. Figures 10-14 are graphical representations of each influence attribute identified categorized by Nurse, Non-nurse and in Aggregate. Also included are qualitative descriptive comments of each influence attribute that reflect the attribute and definitions of the term.

Influence Attributes of Authority

The influence factor - Authority and the related influence attributes - Accountability and Responsibility as defined in the AIM Iteration Five were represented both explicitly and contextually within the survey response data analyzed. The operational definition for Accountability is the state of being liable, or answerable (accountability, n.d.). Responses such as the ones below are representative of respondent comments scored as the influence attribute - accountability.
“The … (department) has gotten progressively busier-acuity higher-It would be of benefit to see … (leadership) have clinically. aware/smart assistant head nurses to improve accountability & follow thru of nursing care a lot is getting missed…” #446 Nursing

“Management does a lot of "lip service" but doesn't follow through on correcting some of the major problems, i.e. communications, + hiring inexperienced staff that act like technicians not therapists. More education needs to be given to these people. Apathy appears to be increasing + also in management. Their approach to correcting problems is in putative actions.” #597 Non-nursing

The operational definition of Responsibility is the social force that binds you to the courses of action demanded by that force (responsibility, n.d.). Responses to follow provide examples of the influence attribute - responsibility found within the survey participant responses.

“The resource nurse role is helpful as a technical support but practically speaking has no authority to manage "people" issues. We need permanent resource nurses or asst. managers who can work to address on-going issues. The CNS & Nurse Manager should be an extension of each other with the same leadership authority & responsibility.” #469 Nursing

"I feel a stronger sense of teamwork between myself and the nurses, doctors, and other disciplines specific to my unit than to the … (discipline). And we have a lot of responsibility and should make more money.” #566 Non-nursing

During data analysis a new concept, Access to Resources was identified as an influence attribute of Authority. The operational definition of Access to Resources is, the ability, right, or permission to approach, enter, speak with, or use a source of supply, support, or aid (access, n.d.; resources, n.d.). Responses such as those below are representative of the influence attribute - access to resources.

“...at times it is difficult to obtain linen, and other equipment specifically on the weekend.” #256 Nursing
“There is not enough physical space to accommodate the number of therapists in both the inpatient and outpatient areas of the department. The patient treatment areas in the outpatient department don't always allow for adequate privacy.” #610 Non-nursing

Table 10 represents the quantified totals of influence attribute concepts relating to the influence factor - authority found within this study.

Table 10

<table>
<thead>
<tr>
<th>Influence Factor</th>
<th>Influence Attribute</th>
<th>Total Number of Nursing Comments</th>
<th>Total Number of Non-nursing Comments</th>
<th>Aggregate Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authority</td>
<td>Access to Resources</td>
<td>232</td>
<td>60</td>
<td>292</td>
</tr>
<tr>
<td>Authority</td>
<td>Accountability</td>
<td>78</td>
<td>18</td>
<td>96</td>
</tr>
<tr>
<td>Authority</td>
<td>Responsibility</td>
<td>102</td>
<td>26</td>
<td>128</td>
</tr>
<tr>
<td>Authority</td>
<td>TOTAL</td>
<td>412</td>
<td>104</td>
<td>516</td>
</tr>
</tbody>
</table>

Figure 10. Authority Influence Attributes: Number of Identified Comments
Influence Attributes of Communication Traits

The influence factor - communication traits and the related influence attributes - confidence, emotional involvement, message articulation and persistence as defined in Iteration Five of the AIM were represented both explicitly and contextually within the survey responses analyzed. Table 11 represents the quantified totals of influence attribute concepts relating to the influence factor - communication traits found within this study.

The operational definition for the influence attribute - confidence is, belief in oneself and one's powers or abilities (confidence, n.d.). Examples of the influence attribute - confidence as found in the data were reflected in statements such as:

“My unit could use a course in conflict resolution with other nursing staff and how to foster confidence & competence in all nurses or new to the unit. Change of shift can be high with conflict. #372 Nursing

“…only when the person stands up for them self and confronts them do they back down and stop. #96 Nursing

The operational definition of the influence attribute - emotional involvement is to engage the interests or emotions or commitment of (involvement, n.d.). The influence attribute - emotional involvement was exemplified in the data as follows:

“I feel that nursing at … (hospital) is one of the greatest in … (location), maybe even the country. I feel respected as a professional. I am proud and lucky to work here. #52 Nursing

“The director of the … department is a wonderful advocate and representative of our service throughout the hospital and administration. She is dedicated to our staff and strives to reach sound decisions and achieve collective goals in a positive and diplomatic style. She sets the tone for the … department, and I can‘t imagine a better work environment or colleagues.” #618 Non-nursing
The influence attribute - message articulation operationalized within the AIM is the shape or manner in which things come together and a connection is made (articulation, n.d.). The influence attribute - message articulation was identified by respondents through comments such as:

“The CNS … (in the department) it is wonderful... kind. Fair, knowledgeable - even when she needs to discuss an issue it is done professionally… the CNS for … (department) is knowledgeable but at time very unprofessional as to how they approach staff and how they handle issues… I have seen the CNS - badger staff to the point of bordering on harassment till the person is in tears...” #96 Nursing

“She is blessed with the ability to communicate with all levels of staff, is very understanding, rational, level headed and is not afraid to call a spade a spade which apparently was too intimidating for management.” #354 Non-nursing

The operational definition of the influence attribute - persistence is the act of persevering; continuing or repeating behavior (persistence, n.d.). The influence attribute - persistence was represented in the data in statements such as:

“There are constantly family members and patients coming to the desk to complain about overflowing trash barrels and dirty bathrooms. We have addressed this with our … (title) and nothing has changed.” #1 Nursing

“I feel for my unit, it would be helpful to have more frequent staff mtgs. To f/u on a number of issues that had been addressed months earlier.” #62 Nursing

During data analysis a new concept, Presence, was identified as an influence attribute of communication traits. The operational definition of Presence is a quality of self assuredness and effectiveness, or command of attention (presence, n.d.). The newly identified influence attribute - presence emerged in sample statements such as:

“There needs to be more presence on our unit to oversee practice issues.” #180 Nursing
“I feel our department is not represented in places where it should be represented {i.e. department head meetings}. Therefore, we are cut off from information that pertains to the overall institution…” #442 Non-nursing

During data analysis the researcher also identified that one existing AIM concept, physical appeal was best represented as being two unique influence attributes, physical appeal environment and physical appeal self. The operational definition of the influence attribute - physical appeal environment is the ability to attract, interest, amuse, or stimulate the mind or emotions based upon appearance of one’s surroundings (appeal, n.d.). Examples of the influence attribute - physical appeal environment was exemplified in statements such as:

“The staff in our unit adjusting to a new environment. We are all spread out and are trying to adjust to the segregations of rooms. We just need to continue to communicate with one another and remember that it takes time to adjust to it.” #465 Nursing

“The physical space of the … area is inadequate for the types of patients being seen…” #548 Nursing

The operational definition of physical appeal self is the ability to attract, interest, amuse, or stimulate the mind or emotions based upon one’s appearance (appeal, n.d.). An example of the influence attribute - physical appeal self was present in statements such as:

“Staff’s personal appearance. Example, long hair and unkempt uniforms is not always appropriate.” #440 Nursing

Table 11 represents the quantified totals of influence attribute concepts relating to the influence factor - communication traits found within this study.
Table 11

*Influence Attributes of Communication Traits*

<table>
<thead>
<tr>
<th>Influence Factor</th>
<th>Influence Attribute</th>
<th>Total Number of Nursing Comments</th>
<th>Total Number of Non-nursing Comments</th>
<th>Aggregate Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication Traits</td>
<td><em>Confidence</em></td>
<td>35</td>
<td>8</td>
<td>43</td>
</tr>
<tr>
<td>Communication Traits</td>
<td><em>Emotional Involvement</em></td>
<td>171</td>
<td>45</td>
<td>216</td>
</tr>
<tr>
<td>Communication Traits</td>
<td><em>Message Articulation</em></td>
<td>79</td>
<td>21</td>
<td>100</td>
</tr>
<tr>
<td>Communication Traits</td>
<td><em>Persistence</em></td>
<td>25</td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td>Communication Traits</td>
<td><em>Physical Appeal Environment</em></td>
<td>50</td>
<td>22</td>
<td>72</td>
</tr>
<tr>
<td>Communication Traits</td>
<td><em>Physical Appeal Self</em></td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Communication Traits</td>
<td><em>Presence</em></td>
<td>28</td>
<td>6</td>
<td>34</td>
</tr>
<tr>
<td>Communication Traits</td>
<td>TOTAL</td>
<td>392</td>
<td>107</td>
<td>499</td>
</tr>
</tbody>
</table>

Figure 11. Communication Traits Influence Attributes: Number of Identified Comments
Influence Attributes of Knowledge Based Competence

The influence factor - knowledge based competence and the related influence attributes - empirical knowledge, personal knowledge, aesthetic knowledge, ethical knowledge, sociopolitical knowledge as defined in Iteration Five of the AIM were represented within the survey responses analyzed. The operational definition of empirical knowledge is the application of theories of science. Factual knowledge of nursing, the scientific body of nursing knowledge (Carper, 1978). Examples of the influence attribute - empirical knowledge identified by respondents included comments such as:

“The … (department) is a great place to work; the unit is cohesive and supportive. MD's and RN's are up to date with latest treatments. … is a pleasure to work for.” #158 Nursing

“I am honored to work in this department among colleagues who care so much for their patients and continually try to improve their understanding of others and advance their knowledge of disease and injury to better heal those who seek treatment. The leadership is very supportive of one’s efforts and practice.” #606 Non-nursing

The operational definition of personal knowledge is providing means to become more aware of culture, customs, beliefs and emotions (Carper, 1978). The influence attribute - personal knowledge was represented in statements such as:

“I feel that over the last year things have improved my unit concerning proper staffing, safety, greater knowledge of cultural issues, and improved management. Thank-you for everyone’s hard work and thank-you for making my job more enjoyable.” #55 Nursing

“Our skill base requires long-term education and world experience. However, we are continually compensated at a lower level than others with much less education or world experience.” # 576 Non-nursing
The operational definition of *aesthetic knowledge* is envisioning desired outcomes in order to respond with appropriate action. It is creative open, empathetic and holistic (Carper, 1978). Examples of the *influence attribute - aesthetic knowledge* as found in the data were reflected in statements such as:

“I would like to see … (hospital) offer more opportunities for nurses who obtain masters degree to work at advanced levels. I have a perception that many of these positions are often filled by persons from outside hospitals…nurses would say it is not worthwhile to go back to school- it doesn't pay. I would like to feel otherwise and will continue to seek out opportunities as best I can.” #95 Nursing

“Oh my unit there are several areas which if improved I believe would improve patient care. These include: 1) Leadership: Often, RN's are forced to manage staffing/assignments while caring for 3-4 inpatients simultaneously. This equates inadequate support, especially when call-outs are encountered. 2) Rapid response RN's are not allowed to assume patient assignments. Equates to inadequate support. 3) MD to RN communication often does not occur. Example: Pt. status changes and STAT diagnostic study is ordered. Pt. asks RN why he/she is going to test - RN cannot respond…etc.” #133 Nursing

The operational definition of *ethical knowledge* is the capacity to make choices within situations to make moral judgments. Ethical knowing is expressed in Codes, Standards and Ethical Frameworks (Carper, 1978). Respondent statements reflective of the *influence attribute - ethical knowledge* include:

“Most families know how to behave, but the hospital must have strict (and enforced) rules for the families who don't know what is appropriate behavior. #236 Nursing

“I find that the director of our department manages to provide an intellectually stimulating environment to work in, encourages staff interaction, is supportive of staff ideas, and maintains a strong standard of personal and professional ethics.” #478 Non-nursing
The operational definition of *sociopolitical knowledge* is about sociopolitical aspects that affect the health of the population such as class structure, poverty, sexism, racism, etc. (White, 1995). Examples of the *influence attribute - sociopolitical knowledge* identified by respondents and found within the data include:

“I have no interest in "cultural sensitivity." There are two things the hospital must maintain. 1)- regarding workers-administration needs to hire people who can do the job for which they were hired and they need to speak English…2)- As for patients, I refuse to let a "custom" affect care. Our health care system is based on scientific laws and I won’t violate that.” #236 Nursing

“In terms of culturally sensitive care, the greatest barrier I experience is access to interpreters when needed as well as educational materials in various languages for our patients.” #609 Non-nursing

Table 12 represents the quantified totals of *influence attribute* concepts relating to the *influence factor - knowledge based competence* found within this study.

### Table 12

<table>
<thead>
<tr>
<th>Influence Factor</th>
<th>Influence Attribute</th>
<th>Total Number of Nursing Comments</th>
<th>Total Number of Non-nursing Comments</th>
<th>Aggregate Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge Based Competence</td>
<td>Empirical Knowledge</td>
<td>74</td>
<td>18</td>
<td>92</td>
</tr>
<tr>
<td>Knowledge Based Competence</td>
<td>Personal Knowledge</td>
<td>45</td>
<td>2</td>
<td>47</td>
</tr>
<tr>
<td>Knowledge Based Competence</td>
<td>Aesthetic Knowledge</td>
<td>15</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Knowledge Based Competence</td>
<td>Ethical Knowledge</td>
<td>11</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Knowledge Based Competence</td>
<td>Sociopolitical Knowledge</td>
<td>12</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Knowledge Based Competence</td>
<td>TOTAL</td>
<td>157</td>
<td>23</td>
<td>180</td>
</tr>
</tbody>
</table>
Some challenges arose surrounding a lack of specificity of within respondent commentary. In particular, the influence attributes of knowledge based competence were challenging to score because some “knowledge” comments lacked specificity. An example of this would include statements such as:

“I would really appreciate more in house educational opportunities for bedside nurses in critical care. We have a lot of expert CNSs that could share their knowledge with us.” #93 Nursing

“Knowledge sharing should be a standard at … (hospital).” #436 Nursing
Additionally there was one response, specifying the concept of competence.

“My unit could use a course in conflict resolution with other nursing staff and how to foster confidence & competence in all nurses or new to the unit. Change of shift can be high with conflict.” #372 Nursing

For purposes of this study, unspecified or “general” knowledge concepts and the competence concept were coded as the influence attribute - empirical knowledge.

Influence Attributes of Status

The influence factor - status and the related influence attributes - hierarchical position, key relationships (renamed key supportive relationships) and reputation as defined in Iteration Five of the AIM were represented both explicitly and contextually within the survey responses analyzed. The operational definition for hierarchical position is an organized body of officials in successive ranks or orders (hierarchy, n.d.; position, n.d.). The influence attribute - hierarchical position as represented within the data would include the following examples.

“… (hospital) is fortunate to have … (CNE) at the helm. #99 Nursing

“I've worked in many different hospitals throughout my career and I've never seen nursing as well supported as I have at … (hospital). From the highest-ranking management, to our own individual floor managers, as well as to each other, we make supporting our career in nursing a very high priority, and it shows.” #106 Nursing

The operational definition for key supportive relationships is an emotional or other connection between people (relationship, n.d.). The influence attribute - key supportive relationships was exemplified in the data in statements such as:

“I feel that as whole, staff members on my unit work well together. I truly enjoy the people I work with: they are great in tough clinical situations, and very cohesive from a clinical standpoint.” #47 Nursing

“I work in … (department) am stunned at how 1/2 of the … (physicians) treat the staff in rudeness, disrespect, and dismissive behavior. …
(proper name) has been rude, moody + unpredictable in his behavior. … (pronoun) walks by staff not acknowledging them. And talks to staff only when … (pronoun’s) angry about something, making the environment very difficult to work in, very tense when he is on the unit.

#576 Non-nursing

The operational definition for reputation is a favorable and publicly recognized name or standing for merit, achievement, reliability (reputation, n.d.). Examples of the influence attribute - reputation found within the data included:

“Our Nurse Manager looks great on paper; however, her leadership is very ineffective and in many ways inappropriate.” #410 Nursing

“… (Proper name) has been an outstanding nurse manager…From what others tell me, we have been blessed to have her.” #249 Nursing

During data analysis it was identified that one new concept, informal position, was an influence attribute of status. The operational definition of informal position is unconventional status or standing, without formality (informal, n.d.; position, n.d.).

Examples of the influence attribute - informal position found within the data are included statements such as:

“I am very concerned about the impression that there is a select group of nurses who seem to "run the show", so to speak. Newer nurses are asked for opinions with conflicts or new policy changes, yet it seems like a token gesture, as things only happen if they are approved by the select group.” #47 Nursing

“I do not get the impression that all members of our staff are treated equally with regard to expectations and opportunities for continuing education. Certain decisions made and the reasons for making them are sometimes unclear, inequitable, and not open for discussion.” #574 Non-nursing
Table 13 represents the quantified totals of *influence attribute* concepts relating to the *influence factor - status* found within this study.

Table 13

**Influence Attributes of Status**

<table>
<thead>
<tr>
<th>Influence Factor</th>
<th>Influence Attribute</th>
<th>Total Number of Nursing Comments</th>
<th>Total Number of Non-nursing Comments</th>
<th>Aggregate Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
<td>Hierarchical Position</td>
<td>73</td>
<td>23</td>
<td>96</td>
</tr>
<tr>
<td>Status</td>
<td>Informal Position</td>
<td>54</td>
<td>12</td>
<td>66</td>
</tr>
<tr>
<td>Status</td>
<td>Key Supportive Relationships</td>
<td>276</td>
<td>65</td>
<td>341</td>
</tr>
<tr>
<td>Status</td>
<td>Reputation</td>
<td>13</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td>Status</td>
<td>TOTAL</td>
<td>416</td>
<td>109</td>
<td>525</td>
</tr>
</tbody>
</table>

Figure 13. Status Influence Attributes: Number of Identified Comments
Influence Attributes of Use of Time and Timing

The influence factor - use of time and timing and the related influence attributes - amount of time to sell the issue and timing to deliver the issue as defined in Iteration Five of the AIM were represented both explicitly and contextually within the survey responses analyzed. The operational definition for amount of time to sell the issue is a limited period or interval, as between two successive events (time, n.d.). Examples of the influence attribute - amount of time to sell the issue found within the data included:

“I feel that change of shift takes too long causing both shifts to leave/start late. This has been addressed in the past without resolution as of yet. All nurses, MD's, and pts would be much happier and appreciative if change of shift could run more smoothly, timely, and efficiently allowing oncoming staff to be prepared and ready at the correct shift start time.” #48 Nursing

“Feel I spend a lot of time reading charts and pushing people off and also feel like I am constantly trying to catch up, meet my pts needs and the team {all workers} needs. This can be very frustrating. I don't like having to always make promises that I'm coming and apologies that I didn't come sooner.” #595 Non-nursing

The operational definition of timing to deliver the issue is the selecting of the best time or speed for doing something in order to achieve the desired or maximum result (timing, n.d.). Examples of the influence attribute - timing to deliver the issue found within the data were present in statements such as:

“The ER has got to improve its way of handing patients to the floors. A lot of times, the bed has been ready for a long time and the ER waits to send the patients up until just about the end of the shift or at change of shift... which poses a danger to the patient because the receiving nurse is either in the frenzy of getting ready to leave or is just coming on and has not even received report yet resulting in the patient not really being attended to when they initially come up. " #160 Nursing

“Would like to see more teaching sessions in the am. Grand rounds are great but most cannot make it due to working off shift.” #215 Nursing
Table 14 represents the quantified totals of influence attribute concepts relating to the influence factor - use of time and timing found within this study.

Table 14

**Use of Time and Timing**

<table>
<thead>
<tr>
<th>Influence Factor</th>
<th>Influence Attribute</th>
<th>Total Number of Nursing Comments</th>
<th>Total Number of Non-nursing Comments</th>
<th>Aggregate Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Time and Timing</td>
<td>Amount of Time to Sell the Issue</td>
<td>78</td>
<td>21</td>
<td>99</td>
</tr>
<tr>
<td>Use of Time and Timing</td>
<td>Timing to Deliver the Issue</td>
<td>11</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Use of Time and Timing</td>
<td>TOTAL</td>
<td>89</td>
<td>21</td>
<td>110</td>
</tr>
</tbody>
</table>

Figure 14. Use of Time and Timing Influence Attributes: Number of Identified Comment
Summary

Each of the influence factor concepts identified in the AIM Iteration Five was identified within the context of data analyzed for this study. Each of the influence factor concepts was validated as valuable and necessary for the CNE and patient care executive team seeking to influence and maximize the professional practice environment. There was only minor variation (1-2%) in the number of times influence factor concepts were identified within four of the five categories when comparing nurse and non-nurse responses. The only influence factor with greater than a 2% variation by respondent category was knowledge based competence. Nursing identified 10% of all concepts being attributes of the influence factor - knowledge based competence whereas non-nursing identified only 6% being attributes of knowledge based competence. This was an interesting finding and may be representative of a greater emphasis on knowledge in achieving influence as identified by nurse respondents.

In the aggregate, status was the influence factor most frequently identified (28% of all concepts) followed by authority (27% of all concepts), communication traits (26% of all concepts), knowledge based competence (9% of all concepts) and use of time & timing (6% of all concepts) respectively. Four percent of concepts were unclassifiable as it was determined that they did not pertain to the concept of influence.

While there were slight modifications to a few influence attribute concepts identified within the AIM Iteration Five such as the specification of physical appeal environment and physical appeal self, each of the revised concepts were represented within the data analyzed. Influence attributes most frequently identified included key supportive relationships (341 conceptual references), access to resources (292 conceptual
references) and emotional involvement (216 conceptual references). Those influence attributes identified least frequently included physical appeal self (4 conceptual references), timing to deliver the issue (11 conceptual references) and ethical knowledge (12 conceptual references).

While the quantification of concepts identified was of interest, it is important to note that within the context of this study the number of times an influence factor or influence attribute was identified was not analyzed in relation to its importance in achieving influence. The findings from this study are representative of concepts identified by respondents as valuable for the CNE in maximizing the Professional Practice Environment. These data are supportive of the influence factors, influence attributes, structure and operational definitions used in the Adams Influence Model.
CHAPTER SIX – DISCUSSION

Introduction

The primary purpose of this study was to validate and/or refine the literature based Adams Influence Model (Iteration Five) as represented in Figure 3 following secondary analysis of qualitative data collected as part of a large medical center’s evaluation of the Professional Practice Environment. Within this context, the following questions were asked;

1. What influence concepts, as defined by the AIM, are identified by a nursing and multidisciplinary professional staff as necessary for the CNE and patient care services executive team seeking to maximize the professional practice environment?

2. What are the influence factors and influence attributes identified most frequently by multidisciplinary professional staff responding to the Professional Practice Environment survey?

3. How does data from this analysis support or refute the factors, attributes and related definitions as described within the AIM?

The study involved secondary data analysis using directed content analysis and evaluation of 726 qualitative commentary responses which was one component of a data set from the Professional Practice Environment survey distributed at an academic medical center. The directed content analysis was coded and scored using concepts from the Adams Influence Model (Iteration Five) as an initial framework. The AIM (Iteration Five) was based upon literature review, nursing theory, pilot studies and experiential
knowledge. This study was designed to validate and refine the AIM through exposure to an external data source.

Linking Study Results to the Model

Influence factors (authority, communication traits, knowledge based competence, status and time & timing) previously identified as the broadest categorizations within the Adams Influence Model (Iteration Five) were supported/validated by staff respondents’ comments within Part IV of the Professional Practice Environment survey. The findings from this study suggest that both nurse and non-nurse professionals readily identify each of the influence factors as concepts, valuable and necessary for the CNE and patient care executive team seeking to influence and maximize the professional practice environment.

During the process of data analysis, the majority of influence attributes and their operational definitions were validated, (19 of 20). The single influence attribute and operational definition from the AIM Iteration Five that was not specifically validated was physical appeal. Challenges around coding of physical appeal occurred because the concept was too broad a categorization. Once the physical appeal concept was separated into the stand alone influence attributes, physical appeal self and physical appeal environment data analysis became much clearer.

Data analysis also led to the identification of three new influence attribute concepts. These included, informal position (an attribute of status), presence (an attribute of communication traits) and access to resources (an attribute of authority). It was also identified that the influence attribute - key relationships (an attribute of status) should be renamed to key supportive relationships (an attribute of status). This renamed attribute specifically “supportive” relationships more accurately represented the concepts
identified in the data analysis and the conceptualization of the AIM as represented in Figure 15. These revisions are also representative of updated conceptual definitions which can be found in Table 15.

The AIM Refined Based on Data Analysis

Figure 15. Adams Influence Model – Iteration Six (November 2008)
<table>
<thead>
<tr>
<th>Influence Factors</th>
<th>Operational Definition</th>
<th>Influence Attributes</th>
<th>Operational Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authority</td>
<td>The right to take actions or responsibility (Hicks, 1972)</td>
<td>Access to Resources</td>
<td>The ability, right, or permission to approach, enter, speak with, or use a source of supply, support, or aid (access, n.d.; resources, n.d.).</td>
</tr>
<tr>
<td>Accountability</td>
<td>The state of being liable, or answerable (accountability, n.d.)</td>
<td>Responsibility</td>
<td>The social force that binds you to the courses of action demanded by that force (responsibility, n.d.)</td>
</tr>
<tr>
<td>Communication</td>
<td>The proficiency or dexterity with which one relates or interacts with individuals</td>
<td>Message Articulation</td>
<td>The shape or manner in which things come together and a connection is made (articulation, n.d.).</td>
</tr>
<tr>
<td>Emotional Involvement</td>
<td>To engage the interests or emotions or commitment of (involvement, n.d.)</td>
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<tr>
<td>Influence Factors</td>
<td>Operational Definition</td>
<td>Influence Attributes</td>
<td>Operational Definition</td>
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<tr>
<td>Persistence</td>
<td>The act of persevering; continuing or repeating behavior (persistence, n.d.)</td>
<td>Presence</td>
<td>A quality of self assuredness and effectiveness, or command of attention (presence, n.d.)</td>
</tr>
<tr>
<td>Presence</td>
<td>Belief in oneself and one's powers or abilities (confidence, n.d.)</td>
<td>Physical Appeal Self</td>
<td>The ability to attract, interest, amuse, or stimulate the mind or emotions based upon appearance of one's surroundings (appeal, n.d.)</td>
</tr>
<tr>
<td>Physical Appeal Environment</td>
<td></td>
<td>Aesthetic Knowledge</td>
<td>Envisioning desired outcomes in order to respond with appropriate action. It is creative open, empathetic and holistic (Carper, 1978).</td>
</tr>
<tr>
<td>Knowledge Based Competence</td>
<td>The quality of being adequately or well qualified intellectually so as to meet or exceed standards of performance (competence, n.d.)</td>
<td>Empirical Knowledge</td>
<td>The application of theories of science. Factual knowledge of nursing, the scientific body of nursing knowledge (Carper, 1978).</td>
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<thead>
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<th>Influence Attributes</th>
<th>Operational Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethical Knowledge</td>
<td>The capacity to make choices within situations to make moral judgments. Ethical knowing is expressed in Codes, Standards and Ethical Frameworks (Carper, 1978).</td>
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<tr>
<td>Personal Knowledge</td>
<td>Providing means to become more aware of culture, customs, beliefs and emotions (Carper, 1978).</td>
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</tr>
<tr>
<td>Sociopolitical Knowledge</td>
<td>Some sociopolitical areas that affect the health of the population are class structure, poverty, sexism, racism, etc. (White, 1995).</td>
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<tr>
<td>Status</td>
<td>Having high standing or prestige (status, n.d.)</td>
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<tr>
<td>Hierarchical Position</td>
<td>An organized body of officials in successive ranks or orders (hierarchy, n.d.; position, n.d.)</td>
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<tr>
<td>Informal Position</td>
<td>Unconventional status or standing, without formality (informal, n.d.; position, n.d.).</td>
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<tr>
<td>Key Supportive Relationships</td>
<td>An emotional or other connection between people emotional or other connection between people (relationship, n.d.)</td>
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<tr>
<td>Reputation</td>
<td>A favorable and publicly recognized name or standing for merit, achievement, reliability (reputation, n.d.)</td>
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Table continues
<table>
<thead>
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<th>Operational Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Time and Timing</td>
<td>Amount of time to sell the issue</td>
<td>A limited period or interval, as between two successive events (time, n.d.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Timing to deliver the issue</td>
<td>The selecting of the best time or speed for doing something in order to achieve the desired or maximum result (timing, n.d.)</td>
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</tbody>
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Additional Operational Definitions within the AIM

Nurse

A healthcare professional dedicated to meaning-making and influencing patient integration, and humanization in the person-environment situation of which health, illness, and health-within-illness are possibilities (Willis et al., 2008).

Target of Influence

One to be influenced or changed by an individual, action or event (target, n.d.).

Feedback

A reaction or response to a particular process or activity (feedback, n.d.).

Interventions/Tactics

Care or measures provided to improve a situation or outcome (intervention, n.d.).
<table>
<thead>
<tr>
<th>Perception(s)</th>
<th>Perception of Self focused on self (perception, n.d.)</th>
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<tbody>
<tr>
<td></td>
<td>Perception of Other(s) focused on others (perception, n.d.)</td>
</tr>
<tr>
<td></td>
<td>Perception of Organization focused on organization (perception, n.d.)</td>
</tr>
<tr>
<td></td>
<td>Perception of Environment focused on environment (perception, n.d.)</td>
</tr>
<tr>
<td>Influence</td>
<td>Influence is best defined as the ability of an individual (agent) to sway or affect another person or group (target) based on authority, status, knowledge based competence, communication traits and use of time and timing (influence, n.d.)</td>
</tr>
<tr>
<td>Personal System</td>
<td>An individual utilizing information (King, 1981)</td>
</tr>
<tr>
<td>Interpersonal System</td>
<td>Groups of individuals including dyads, triads as well as groups whereas complexity and variability increase with its size (King, 1981).</td>
</tr>
<tr>
<td>Social System</td>
<td>An organized boundary system of social roles, behaviors and practices to maintain values and the mechanisms to regulate the practices and rules (King, 1981).</td>
</tr>
<tr>
<td>Power</td>
<td>the cumulative of being influential over several single issues</td>
</tr>
</tbody>
</table>
Limitations

There are at least five interrelated limitations of this study. First, the study design used a secondary analysis of an existing data aimed at understanding the clinician perception of the professional practice environment. Data from the initial source study was not collected to measure CNE or clinician leadership influence. Hence, future research specifically set on identifying influence factors and influence attributes within this population is necessary.

A second limitation within this study surrounds the specificity of responses. The data analysis was limited by the lack of specificity within some responses. For example the concept of “Knowledge” was identified and categorized within the influence factor - knowledge based competence. However, further categorization to the influence attribute was a challenge primarily because the source data was not originally collected for purposes of defining influence and did not contain concept specificity inclusive of knowledge based competence influence attributes.

Third, while there was a significant sample size, there were limitations surrounding the frequency particular AIM influence factors or influence attributes were identified within the data source. An example would include the influence attribute - physical appeal self whereby the concept physical appeal self may have an impact on the likelihood that one achieves influence. However, it was not frequently identified within the source data. This may be because the nature of the source survey did not lend itself to address physical appeal self.

The fourth and fifth identified limitations of this study were related to the data sample. The initial source of data analyzed was obtained by volunteered self selection. The initial participation in the SPPE survey by clinical staff was strictly voluntary. While
the overwhelming majority of staff did participate and is represented as part of the data analyzed, the self selection may have included or eliminated persons who would have included identifiable concepts necessary for influence. The source for data analyzed as part of this study was employees within the Patient Care Services cost center. The respondents were all from a single academic teaching hospital in New England designated as Magnet. Thus, participant responses used may not be representative of every hospital environment or locale.

Implications for the AIM

The AIM can be used as a guide for CNE and more broadly nursing education, policy, practice, research and theory. The AIM provides a framework for focus on enhancement of influence and expansion of nursing opportunity to achieve influence. The following implications were identified as potential uses of the AIM for enhancement of education, policy, practice, research and theory.

Implications for Education

The AIM can be used as a structure by which professional nursing (in particular nursing administration) education is structured. After nearly a decade of downward trends in enrollment and total number of nursing administration programs, the Council for Graduate Education in Administrative Nursing (CGEAN) just started to report anecdotal increases in these numbers (Herrin, Jones, Krepper, Sherman, & Reineck, 2006; Rudan, 2002). However, CGEAN also reported a growing concern surrounding the new shift toward Doctor of Nursing Practice (DNP) as preparation for CNE and leadership roles. This shift could result in Nurse Executives seeking alternative educational routes such as a non-nursing masters programs (MBA or MHA) due to time constraints in their current leadership role and confusion as to the direction of the
expanding on the nurse’s need to understand influence would prove a valuable asset for all nurses and the profession of nursing. For example, Nurse Practitioners are often hired and managed by physicians, and staff nurses in many institutions are assumed to have a subservient role. The AIM can serve as a model to prepare nurses who will be employed in such environments. Using the AIM as a guide will help those nurses to realize their professional potential and influence based on their unique knowledge based competence, status, authority, communication traits, use of time and timing, and tactics/interventions.

While some influence factors and influence attributes are somewhat fixed or dependent upon circumstance, i.e. hierarchical position or time to address the issue, there are specific influence factors and influence attributes that are less static and can be targeted during nursing education. For example, each of the influence attributes of knowledge based competence can be targeted/honed as part of educational preparation. Additionally, strategies for improving communication traits such as confidence, persistence and/or message articulation could be targeted during formal coursework.
Implications for Policy

The process of policy proposal and development is admittedly a case study in influence. Using the AIM may ultimately help identify the likelihood of achieving influence and/or help in setting strategies for enhancing the ability to influence. From a professional perspective, using the AIM may help increase the identity and expressed value of the profession within the policy arena. The AIM can be used as a framework for articulating and communicating the message of the discipline, changing behaviors and perceptions of the discipline, and taking knowledge based nursing messages forward. Undoubtedly, nurses and the profession would benefit significantly from an increased awareness around the process of attaining influence. As the United States health care system will inevitably and significantly change over the next decade, the AIM and its associated concepts provide a framework for nurses to influence policy based on understanding their own and their target’s knowledge based competence, communication traits, authority, status, use of time and timing. This understanding, coupled with selection of influence tactics/ interventions gives the 5000 CNEs (Health Forum, 2006) and the 2.4 million nurses (Bureau of Labor Statistics, 2007) an opportunity to influence legislative changes on the local, state, national and international levels through direct engagement.

Implications for Practice

When used as a practice model, the AIM can help nurses focus and increase their impact to positively influence the health and well-being of persons individually, organizationally, locally, nationally and/or globally. Each of the concepts contained within the AIM consist of operational definitions that can easily be framed for use in
administrative and/or clinical practice settings. The AIM can be used as a tool or framework to guide empowerment of the staff nurse and thus the patient through improving knowledge based competence (KBC), communication traits, accountability, and responsibility to enhance practice, improve satisfaction and procure outcomes. KBC in particular suggests that nurses engage in problem solving as opposed to merely achieving a desired outcome (Rogers, 2008). KBC emphasizes that there are multiple ways that nurses “know,” one of which is through evidence. KBC provides a justification for nursing practice based upon aesthetic empirical, ethical, personal and sociopolitical knowledge which is grounded in the discipline. KBC is inclusive of but not limited to empirical evidence, suggesting that Evidence Based Practice is a misnomer and Knowledge Based Practice more accurately represents the problem solving nurses use to influence patient well being. While the concept of “Influence” can be somewhat controversial when discussing patient care within the context of honoring the patient, influencing his/ her well being is exactly what nurses try to accomplish on a routine basis.

While not an intended directive within this study, an unintended consequence pointed to the identification of the PPWE as potentially the single most effective measure of success for the nurse executive. The state of Chief Nursing Executive (CNE) education, role and practice in the United States is at a critical juncture. A 2005 study, funded by the American Organization of Nurse Executives found that approximately 40% of CNEs “turned over” at least one time during their career, with approximately 62% of the CNE respondents reporting that that they anticipate making a job change in less than 5 years (Jones, Havens & Thompson, 2008). This high turnover rate is often associated with a lack of role clarity, undefined expectations and a lack of measures of success for many CNEs. Adams and colleagues (2008) identified a discrepancy surrounding
“success” for nurse executives as defined by different constituencies (superiors, peers or subordinates). Compounding this problem, recruiters and recruitment firms charged with filling these vacancies, use varying criteria when seeking CNE candidates causing significant role and disciplinary confusion. The measures surrounding professional practice/ work environments are an inclusive categorization of all criteria valued by each of the nurse executive’s constituencies, (executives, peers and subordinates). This is representative of the only existing guidelines for nurse executive practice, the ANA Scope and Standards for Nurse Administrators and the AONE Core Competencies. Thus, the Professional Practice/ Work Environment as the focus of CNE influence and the PPWE as a universal measure of CNE success must be explored further.

Implications for Research

A defined goal of most if not all funded research is to influence. Thus, use of the AIM in research creates a unique framework for study and possibly more importantly dissemination of research findings. Future research includes the continued testing of the components of The Influence Relationship Framework found in Figure 16, the development of instruments to measure influence, the components of the AIM and the impact of the AIM concepts on achieving influence as a follow up to understanding influence within or on the Professional Practice Environment.

Continued study of the AIM in its entirety as well as with isolated focus on influence factors, influence attributes and other pertinent concepts is imperative for continued enhancement of the model and understanding of influence. More specific research and development of the AIM must also occur, examples include: instrument development based on influence factors and influence attributes, exploration of influence factors such as communication traits and the impact of influence attributes can focus
research on message articulation during shift handover or physical appeal self assessing the impact of clinician use of identifiable uniforms. Research initiatives which aid in the further specificity of influence attributes like access to resources into categories such as human resources, information resources, financial resources and physical resources are also necessary. When used as a framework for research, the implications of the AIM are endless, ranging from understanding the influence of nurses within health policy arenas (influence tactics/ interventions) to the effectiveness of a structured verbal shift report (message articulation) to the impact of a nursing staff uniform policy on patient satisfaction (physical appeal self).

Extending the AIM to New Populations

While the initial intent of the AIM was to define influence within the nurse executive population, it is hypothesized that the model can be extended to other populations. In particular, a goal for all nurses should be to positively influence the health and well-being of persons individually, organizationally, locally, nationally and/or globally. Thus, the AIM is a unique framework by which we can begin to structure and focus means by which this can best be achieved. The AIM, when used as a framework, will help guide and impact nursing education, policy, practice, research, and theory and would prove applicable in understanding influence in any setting, be it interpersonal, small group, large group or mass media. This hypothesis is based on the work of Hopkins (1964), suggesting that within a group, the true group leader will most often be followed and should be the target of influence. It is also likely that this model is applicable to group scenarios including mass media communication; however more research must be done to confirm these hypotheses.
Implications for Theory

The phenomenon “influence” has implications for development of nursing education, policy, practice, research and theory. The model itself is a framework that can bridge with most grand nursing theories and can enable further research related to testing and refinement of the theory as related to nursing and particular nursing administration. The AIM can guide the advancement of practice and education with the development of self-assessment tools, curriculum development and strategies to enhance nursing influence across various clinical and administrative roles. While there are several definitions of and paradigms for nursing, depending upon one’s theoretical perspective (Newman, Smith, Pharris, & Jones, 2008), nursing within this study was adapted from Willis, Grace and Roy’s (2008) description. The definition of nursing within in the development of the AIM and within this study is meaning-making, influencing patient integration and humanization in the person-environment situation of which health, illness, and health-within-illness are possibilities. This slightly modified definition includes the concept of influencing patient integration as opposed to facilitating integration as suggested by Willis and colleagues.

Implicitly, influence and the concepts of influence are a significant part of nursing theories and definitions of nursing. The following exemplar depicts the inclusion of influence across three prominent nursing theories, King’s Theory of Goal Attainment (King, 1981), Newman’s Theory of Health as Expanding Consciousness (Newman, 2008) and Roy’s Adaptation Theory (Roy, 2008).

**CNE Influence and Nursing Theory Exemplar.**

A CNE seeks to attain a goal. This goal is to influence the executive team for an approved allocation of increased funding for internal staff research training (Goal Attainment). The CNE consciously or subconsciously takes inventory of the influence factors and attributes necessary to achieve influence. This leads to a
self awareness or pattern (Health as Expanding Consciousness) based on her/his lived experiences and place in the world. This self-awareness, focuses the CNE to select a tactic/ intervention based upon both the self reflection and perception of the influence target. This tactic/ intervention may involve Rational Persuasion, Coalition Building, etc. At this stage in the process given a tactic/ intervention chosen, the influence target will provide feedback. This feedback will either signify influence achieved or the CNE must adapt (Adaptation) based on this new knowledge and the CNE can then begin the influence process again.

The process of influence from planning for goal attainment, self and target awareness and pattern recognition to adapting based upon feedback are of significance. The consilience, or melding, of these and other nursing theories provides a continued expansion of nursing’s ability to influence and meet the needs of individuals and society. How nurses plan, reason, and adapt as well as use knowledge, status, authority, communication traits, and time influences health improvement, health maintenance/wellness and the environment of care.

The AIM is believed to be an effective, practical and understandable practice model for all nursing and clinical care delivery from staff to manager to executive. The majority of practice models define a philosophy of care and are designed based on role expectations or defining or describing the nurse/ clinician (Brennan & Anthony, 1997). The AIM is designed as a supplement to this role-based model toward identifying a process framework that the nurse CNE can utilize toward improving themselves and articulate their influence on patient health.

Influence and Power Theory

An additional theory implication for the AIM is the understanding of Influence as it relates to the concept of Power. It is not unusual to hear in casual conversation that an individual is or is not influential or powerful. The broad concepts of influence and power are often used interchangeably and to define one another (Kipnis, 1976; Kipnis & Schmidt, 1988; Kipnis et al., 1980; Rajan & Krishnan, 2002). However, while these
concepts are related, they were inferentially identified as distinctly differing. Power within the context of the AIM was conceptualized as being influential over many single issues and likely across domains. In contrast, influence within the AIM focused on a singular issue. It is crucial to recognize the difference as each individual is more or less influential based on any given single issue (Dutton & Ashford, 1993).

One definition of power as an accumulation of influence over several singular issues can be best described as both complimentary and contrasting to nursing’s own prevailing definition of power. This definition suggests power as the capacity to participate knowingly in the nature of change whereby it is manifested in awareness, choices, freedom to act intentionally and an involvement in creating change (Barrett, 2000). Barrett’s concept of power, developed from a Rogerian perspective, can be explained as a broader (non singular issue or meta perspective) of the influence process described in the agent perception, tactics/ intervention, target perception, feedback process described in the AIM (Barrett, 2000). By the same token, given one’s perspective, it could be argued that the AIM and Barrett’s Power Theory simply use a variant name (influence as opposed to power), with differing constructs to understand the same or similar concept. In either scenario, use of the Adams Influence Model and Barrett’s Power Theory are solely frameworks and perspectives for enhanced knowledge development stemming from the nursing discipline. These concepts will need to be explored and tested further to articulate the similarities and differences between power and influence and their relationship to nursing theory development.

Considerations for Future Application, Use and Impact of the AIM

While the validation and refinement The Adams Influence Model was the central intent of this study, additional new insights emerged as the result of this research. An
emerging framework depicted in Figure 16, represented the relationship between CNEs, Professional Practice/ Work Environments (PPWE) and patient outcomes. This framework identifies opportunity for the focus of CNE influence to address the PPWE. The evolution of this framework stemmed from; discussions with subject matter experts, immersion in the source data used in this study, and evaluation of literature focused on influence, CNEs, and the PPWE. Couched within this context key issues within the environment of the CNE are emphasized including leadership development, PPWE and organizational/ patient outcomes. Thus, opportunity for application, use and impact of the AIM, SPPE as they relate to each other and organizational/ patient outcomes becomes increasingly valuable throughout nursing education, policy, practice, research and theory.

Figure 16. The Influence Relationship Framework: CNE, PPWE and Patient Outcomes

Two of the three legs of this framework have been well discussed in the literature. Existing literature suggests that the Nurse Executive can and does greatly influence the PPWE (American Nurses Association, 1995; American Organization of Nurse Executives, 2005; Institute of Medicine, 2004; McClure & Hinshaw, 2002). Research
has also shown that acute care facilities found to have positive patient outcomes also possess certain organizational characteristics, most notably positive PPWEs (Aiken, 2002; Aiken et al., 2002; Aiken et al., 1994). It is however the third leg, “Nurse Executive Influence Patient Outcomes,” that will likely have the greatest implications for use of the AIM in education, policy, practice, research and theory.

Patient outcomes in their various forms of satisfaction, mortality rates, hospital readmissions, etc. are the gold standard measure of success for healthcare organizations (Adams, 2007). Health care organizations, specifically acute care facilities are continuously evaluated based on a variety of these measures. Based upon The Influence Relationship Framework in Figure 16, the CNE and the patient care leadership team can and does influence patient outcomes, through efforts guided toward influencing the PPWE. While the concept of how the CNE can influence and impact PPWEs and thus patient outcomes may inherently exist in research, practice, presentations and education, to date no formal literature has been identified suggesting this linkage.

Conclusion

Ultimately, this study has led to the refinement and validation of the Adams Influence Model. While results from this study are supportive of the use of the AIM as a framework to guide education, policy, practice, research and theory development throughout nursing and across disciplines, the original intent of the exploration of the phenomenon “influence” was to continue to develop and gain a better understanding of nurse executive practice in the acute care setting.

The AIM is valuable in this context as well. Through this research, it has been concluded that the expansiveness, stresses and challenges associated with the nurse executive position can only truly be understood only by those who have formally served
in this capacity. S/he is responsible for an expansive scope of practice covering multiple disciplines, with more FTEs and a larger budget than any other non-CEO healthcare executive. S/he is evaluated for success by multiple constituency groups many times without a defined measure of what success really is. This study and subsequent refinement of the AIM supports the researcher’s initial intent of the study of influence, which was to ensure that nurse executives had a baseline framework to effectively represent the profession of nursing while addressing the needs of each constituency. Perhaps Rudyard Kipling best helps one grasp a conceptualization of the continual challenge of constituent expectations and the need for Nurse Executive’s mastering of influence in his poem “If”.

“If you can talk with crowds and keep your virtue
Or walk with kings and not lose the common touch,
If neither foes nor loving friends can hurt you,
If all (persons) count with you, but none too much.” - (Kipling, 1910)
Bibliography


Rudan, V. (2002). Where have all the nursing administration students gone? *Journal of Nursing Administration, 32*(4), 185-188.


Protocol IRB: 99.039.01EXE

TO: Adams, Jeffrey
FROM: Institutional Review Board – Office for Research Protections
DATE: July 28, 2008
RE: Validation Of The Adams Influence Model

Notice of Evaluation: [EXEMPT 45 CFR 46.101(b) (4)]

The Office for Research Protections (ORP) has evaluated the project named above. According to the information provided, you intend to validate and/or refine the literature-based Adams Influence Model following secondary analysis of qualitative data collected as part of a large medical center's evaluation of the Professional Practice Environment. This is a minimal risk study.

This study has been granted an exemption from Boston College IRB review in accordance with 45 CFR 46.101(b) (4), which provides exemption for research with pre-existing data sources in which the information will not be recorded in such a manner that subjects can be identified, directly or through identifiers linked to the subjects. This designation is based on the assumption that the materials that you submitted to the ORP contain a complete and accurate description of all the ways in which human subjects are involved in your research.

This exemption is given with the following conditions:

1. You will conduct the project according to the plans and protocol you submitted;
2. No further contact with the ORP is necessary unless you make changes to your project or adverse events or injuries to subjects occur;
3. If you propose to make any changes in the project, you must submit the changes to the ORP for IRB review; you will not initiate any changes until they have been reviewed and approved by the IRB;
4. If any adverse events or injuries to subjects occur, you will report these immediately to the ORP.

The University appreciates your efforts to conduct research in compliance with the federal regulations that have been established to ensure the protection of human subjects in research.

Date of Exemption: July 28, 2008
Application: Notification of IRB Review

Protocol #: 2008-P-001090/1; MGH

Date: 06/16/2008

To: Jeannette Ives Erickson, RN, MSN
   Nursing
   BUL 230B

From: Fred Syllien
   PHS Research Management
   116 Huntington Ave Suite 1002

Title of Protocol: Validation of the Adams Influence Model (AIM)
Version Date: 06/10/2008
Sponsor: Internal Funding
IRB Approval Date: 06/16/2008

This application has been reviewed by a member of the Human Research Committee. They have determined that the research activities described in this proposal do not meet the definition of human subjects research for the following reasons:

- There will be no intervention of interaction with a living person that would not be occurring or would be occurring in some other fashion, but for this research; and
- There will be no identifiable private data/information obtained for this research in a form associated with the individual from whom the human material was obtained. Associate means that the identity of the subject is or may readily be associated with information through direct or indirect identifiers, e.g., codes.

This determination was based upon the DHHS/CHRP Human Subject Regulations Decision Charts. Additional review by the HRC (IRB) is not needed. You will not be required to submit annual progress reports; however, you may not make changes to this research activity without first discussing them with the Human Research Office (IRB) to determine that such changes are consistent with this determination.
Appendix B

AONE Core Competencies

The vision of the American Organization of Nurse Executives (AONE) is to shape the future of healthcare through innovative nursing leadership. Innovative nursing leadership requires that nurses in leadership positions are competent.

AONE believes that managers at all levels must be competent in:
I. Communication and relationship-building
II. A knowledge of the healthcare environment
III. Leadership
IV. Professionalism
V. Business skills

While all nursing leaders share these competency domains, the emphasis on particular competencies will be different depending on the leader’s specific position in the organization.

Communication and relationship-building competencies include:
- Effective communication
- Relationship management
- Influence of behaviors
- Ability to work with diversity
- Shared decision-making
- Community involvement
- Medical staff relationships
- Academic relationships

Leadership skills include:
- Foundational thinking skills
- Personal journey disciplines
- The ability to use systems thinking
- Succession planning
- Change management

Professionalism includes:
- Personal and professional accountability
- Career planning
- Ethics
- Evidence-based clinical and management practice
- Advocacy for the clinical enterprise and for nursing practice
- Active membership in professional organizations

Business skills include:
- Understanding of healthcare financing
- Human resource management and development
- Strategic management
- Marketing
- Information management and technology

The following discussion provides an in-depth description of the skills needed for competency in the five AONE leadership domains.

Knowledge of the healthcare environment includes:
- Clinical practice knowledge
- Patient care delivery model and work design knowledge
- Healthcare economics knowledge
- Healthcare policy knowledge
- Understanding of governance
- Understanding of evidence-based practice
- Outcome measurement
- Knowledge of and dedication to patient safety
- Understanding of utilization/case management
- Knowledge of quality improvement and metrics
- Knowledge of risk management

Appendix C

ANA Scope and Standards for Nurse Administrators

<table>
<thead>
<tr>
<th>Standards of Practice</th>
<th>Standards of Professional Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STANDARD 1. ASSESSMENT</strong> The nurse administrator develops, maintains, and evaluates patient and staff data collection systems and processes to support the practice of nursing and delivery of patient/client/resident care.</td>
<td><strong>STANDARD 2. QUALITY OF CARE AND ADMINISTRATIVE PRACTICE</strong> The nurse administrator systematically evaluates the quality and effectiveness of nursing practice and nursing services administration.</td>
</tr>
<tr>
<td><strong>STANDARD 2. PROBLEMS/DIAGNOSIS</strong> The nurse administrator develops, maintains, and evaluates an environment that empowers and supports the professional nurse in analysis of assessment data and in decisions to determine relevant problems and diagnoses.</td>
<td><strong>STANDARD 3. PERFORMANCE APPRAISAL</strong> The nurse administrator evaluates personal performance based on professional practice standards, relevant statutes, rules and regulations, and organizational criteria.</td>
</tr>
<tr>
<td><strong>STANDARD 3. IDENTIFICATION OF OUTCOMES</strong> The nurse administrator develops, maintains, and evaluates information systems and processes that promote desired, patient/client/resident-defined, professional, and organizational outcomes.</td>
<td><strong>STANDARD 4. PROFESSIONAL KNOWLEDGE</strong> The nurse administrator maintains and demonstrates current knowledge in the administration of healthcare organizations to advance nursing practice and the provision of quality healthcare services.</td>
</tr>
<tr>
<td><strong>STANDARD 4. PLANNING</strong> The nurse administrator develops, maintains, and evaluates organizational systems to facilitate planning for the delivery of care.</td>
<td><strong>STANDARD 5. PROFESSIONAL ENVIRONMENT</strong> The nurse administrator is accountable for providing a professional environment.</td>
</tr>
<tr>
<td><strong>STANDARD 5. IMPLEMENTATION</strong> The nurse administrator develops, maintains, and evaluates organizational systems that support implementation of plans and delivery of care across the continuum.</td>
<td><strong>STANDARD 6. ETHICS</strong> The nurse administrator’s decisions and actions are based on ethical principles.</td>
</tr>
<tr>
<td><strong>STANDARD 6. EVALUATION</strong> The nurse administrator evaluates the plan and its progress in relation to the attainment of outcomes.</td>
<td><strong>STANDARD 12. COLLABORATION</strong> The nurse administrator collaborates with nursing staff at all levels, interdisciplinary teams, executive leaders, and other stakeholders.</td>
</tr>
</tbody>
</table>

Health care has always been subject to change. Our challenge is to ensure that reimbursement models, patient acuity, and stay and other changes in clinical and demographic populations result in patient care that is both effective and efficient. The role of nurse administrators is becoming more critical as the long-term care environment becomes more complex. The nurse administrator must be skilled in utilization of new technology and partnerships in delivering care. The diversity of the patient population and community also support an inclusive environment. The nurse administrator must be prepared to navigate complex systems and the ever-changing health care landscape.

Appendix D

Adams Influence Model – Iteration One (October 2003)
Appendix E

Adams Influence Model – Iteration Three (April 2006)
## Appendix F

### Professional Practice Environment Subscales

<table>
<thead>
<tr>
<th>Organizational Characteristic</th>
<th>Definition</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy</td>
<td>The Quality or state of being self-governing and exercising professional judgment in a timely fashion.</td>
<td>(Aiken, Sochalski, &amp; Lake, 1997)</td>
</tr>
<tr>
<td>Clinician-MD Relations</td>
<td>Relations with physicians that facilitate exchange of important clinical information.</td>
<td>(Aiken, Sochalski et al., 1997)</td>
</tr>
<tr>
<td>Control Over Practice</td>
<td>Sufficient intra-organizational status to influence others and to deploy resources when necessary for good patient care.</td>
<td>(Aiken, Havens, &amp; Sloane, 2000)</td>
</tr>
<tr>
<td>Communication</td>
<td>The degree to which patient care information is related promptly to the people who need to be informed through open channels of communication.</td>
<td>(Shortell, Rousseau, Gillies, Devers, &amp; Simons, 1991)</td>
</tr>
<tr>
<td>Teamwork/ Leadership</td>
<td>A conscious activity aimed at achieving unity of effort in the pursuit of shared objectives.</td>
<td>(Zimmerman et al., 1993)</td>
</tr>
<tr>
<td>Conflict Management/ Handling Disagreements</td>
<td>The degree to which managing conflict is addressed using a problem solving approach.</td>
<td>(Zimmerman et al., 1993)</td>
</tr>
<tr>
<td>Internal Work Motivation</td>
<td>Self-generated motivation completely independent of external factors such as pay, supervision and co-workers.</td>
<td>(Hackman &amp; Oldham, 1976, 1980)</td>
</tr>
<tr>
<td>Cultural Sensitivity</td>
<td>A set of attitudes, practices and/or policies that respects and accepts cultural differences.</td>
<td>(National Center for Cultural Competence, 2004)</td>
</tr>
</tbody>
</table>

Source: (MGH Patient Care Services, 2006)
Appendix G

Example of Qualitative Data Numbering and Coding

- Concerns related to the growing number of staff members, including myself, who have developed plantar fasciitis as a work-related injury in the Same Day Surgical Unit.
  2. Concerns related to work safety in the OR. Multiple cords on the floor create a tripping hazard. 3. Water safety - one surgeon during arthroscopy cases uses a higher flow of water that sprays all over the room creating slippery floors and an unsafe work environment.
  It is also difficult to maintain sterile technique as the water at times sprays on the sterile equip cabinet and flows out of the operating room door. RN's throw blankets on the floor to stop the flow, which create the potential for back injuries for the nursing and support staff to pick them up. 3. Increase support staff to prepare equip for next day cases. It is a waste of Nursing Resources to be picking supplies.
- Infection Control - Equipment in rooms not cleaned in between patients (such as countertops, BP cuff, etc). After patient discharged only mop floor (sometimes) and clean stretcher mattress and change sheet. Usually don't even clean stretcher handrails. Also, patient and visitor bathrooms often dirty. 2. Pt knowledge deficit. Pt's often sent home with poor discharge teaching d/t fast pace of ER. Very few doctors / nurses know how to (or take the time to) access teaching info for patients from PCOI or other databases.
- Would like our unit to be more involved in MGH activities (Blood drive competition between floors, Be Fit program...) 2. Would like to see more MD to Nurse interaction (i.e. rounds).
  A couple of questions were confusing - not sure what was being asked. Would be nice to have a way to convey that though I had to give an answer, I didn't understand the question.
- A portion of the new staff hires has come with no critical care experience. This is a high volume trauma center that requires experienced assessment skills and critical thinking. Although our staff numbers have increased, I have found that many of my colleagues are unequipped to care for patients efficiently in this fast-paced, critical department. I believe a prerequisite of at least 5 years of clinical experience, including at least 2 years of emergency or ICU experience is required before working in the ED.
- After working at a couple of different institutions, I have really come to appreciate and love working as a
Appendix H

AIM Validation Tool - Three

|                         | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z |
| **Empire Records**      |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| **Process Records**     |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| **Activity Records**    |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| **Device Records**      |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| **Software Records**    |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| **System Records**      |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| **Computational Tools** |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| **Display Records**     |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| **User Time and Timing**|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| **Notes**               |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

- **Cell Reference**: C2
- **Field Name**: Hard Copy Number

The table above contains data related to the validation tool, with columns for various records and computational tools, and rows for different types of data entries. The table is used to validate software, hardware, and other components as part of the AIM process.
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November 29, 2008

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Regards,

Alicemary Aspell Adams, MBA, BSN, RN  
Principal

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