

# Factors Enhancing Nurse Leader Influence A Survey of Participants from the 2008 INHL Conference

The Institute for Nursing Healthcare Leadership  
Boston, MA



*Report Prepared by:*  
Jeffrey M. Adams, PhD, RN  
Lisa Paulo, MSN, MPA, RN  
Jeanette Ives Erickson, MS, RN, FAAN  
Alicemary Aspell Adams, MBA, BSN, RN  
Dorothy A. Jones, EdD, RNC, ANP, FAAN  
Joyce C. Clifford, PhD, RN, FAAN

## TABLE OF CONTENTS

	<u>Page</u>
Survey Sponsors, Authors and Acknowledgements	03
Perspective	04
<b>SECTION I: Survey Respondents Demographics &amp; Conference Attendance Statistics</b>	
Age, Gender, Organization Size	05
Primary Title, Primary Employer, Employment Community	06
State (location) of Primary Employment	07
Highest Nursing Education Level, Years Experience in Current Role, Number of Employers	08
Years Experience in Health Care Administration, Professional Organization Membership	09
Most Appealing Aspects of INHL Conference, INHL Conference Attendance Specifics	10
<b>SECTION II: Research Question Results</b>	
Research Questions 1, 2, 3 and 4	11
Discussion	12
Discussion (continued)	13
References	13

IRB approval was obtained for this study through PARTNERS HEALTH SYSTEM #2009-P-00428

This document reports the results of the INHL Executive Nurse Leadership Survey distributed at The Institute for Nursing Healthcare Leadership Conference in June 2008. We thank those who participated in this survey and all those who work for the continued improvement of nursing leadership. We appreciate the wealth of knowledge shared by nurse leaders and look forward to being a part of the continued development of nurses as effective leaders in the ever changing and complex healthcare system.

This report was made possible through the generosity of



[www.svmh.com](http://www.svmh.com)



[www.massgeneral.org](http://www.massgeneral.org)



[www.bogartgroup.com](http://www.bogartgroup.com)

### About the Authors



**Jeffrey M. Adams, PhD, RN**

is a Research Associate with The Institute for Nursing Healthcare Leadership, a Postdoctoral Fellow with the Yvonne L. Munn Center for Nursing Research at the Massachusetts General Hospital, Boston, MA, Nursing Research Consultant with Salinas Valley Memorial Healthcare System, Salinas, CA and a Principal with The Bogart Group, Inc., Monterey, CA



**Lisa Paulo, MSN, MPA, RN**

is the Senior Administrative Director for Patient Care Services at Salinas Valley Memorial Healthcare System, Salinas, CA.



**Jeanette Ives Erickson, MS, RN, FAAN**

is a Senior Associate with The Institute for Nursing Healthcare Leadership and the Senior Vice President of Patient Care Services & Chief Nurse at Massachusetts General Hospital, Boston, MA.



**Alicemary Aspell Adams, MBA, BSN, RN**

is a Doctoral Student and National Security Institute Scholar at the Naval Postgraduate School, Monterey, CA, and a Principal with The Bogart Group, Inc., Monterey, CA



**Dorothy A. Jones, EdD, RNC, ANP, FAAN**

is the Director of the Yvonne L. Munn Center for Nursing Research at the Massachusetts General Hospital, Boston, MA and Professor at the Boston College William Connell School of Nursing, Chestnut Hill, MA



**Joyce C. Clifford, PhD, RN, FAAN**

is the President and CEO of The Institute for Nursing Healthcare Leadership, Boston, MA

*A special thank you to: Irene Neumeister, Sandra Cortes, Chris Fisher, Janice Kiley, Diane Carroll, Deb Fallon, Linda Lyster & Karen Poznick*

Dear Colleagues-

Understanding senior nursing leadership influence is essential for the discipline of nursing. There are approximately 5000 Chief Nurse Executives (CNE) in the United States, all tasked with being the primary identifiable nursing leader representing employing organizations and the discipline of nursing of which they are a part. In this capacity, the CNE is the gatekeeper for the advancement of the majority of the 2.7 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, our research has identified that they still self identify as being less influential than their C-suite counterparts, leaving us to question “Having gotten to that table, now what?”

Over the past 4 years, CNEs have been surveyed at the annual Institute for Nursing Healthcare Leadership (INHL) invitational seminars. These INHL surveys have been designed as an early step toward answering this question. This research thread aims at understanding the influence of the senior nurse leader and identifying how to maximize this influence. The study involved collecting qualitative responses to four research questions. Data were analyzed using qualitative descriptive content analysis and was summarized by themes. We feel the results from this study provide a unique insight into the influence factors and attributes of nursing executive leadership within healthcare organizations.

Through this and related research, it has been made clear that the expansiveness, stresses and challenges associated with nursing leadership, specifically the nurse executive role, can only truly be articulated by those who have formally served in this capacity. The CNE is responsible for an scope of practice covering multiple disciplines, with more FTEs and a larger budget than any other non-CEO healthcare executive. The CNE is evaluated for success by multiple constituency groups, many times without a defined measure of success. This study helps to identify related research potentials including the exploration of; influence instrument development, understanding of the influence process, differentiation between influence and power, and the relationship between CNE influence, work environments and patient outcomes.

Ultimately it is our goal to ensure that nurse executives have a baseline framework to effectively represent the profession of nursing while addressing the needs of each constituency. We feel it is the responsibility of INHL, AONE, nursing administration researchers, along with nurse executives, past, current and future to continue to define and enhance nurse leader influence. At this exciting time in healthcare, many things are evolving, including the role responsibilities of the nurse executive leader. As a discipline and profession, nursing must continue to influence our own future, making sure our leaders are prepared to do so cannot be left to chance.

*Jeffrey M. Adams, PhD, RN*

*Lisa Paulo, MSN, MPA, RN*

*Jeanette Ives Erickson, MS, RN, FAAN*

*Alicemary Aspell Adams, MBA, BSN, RN*

*Dorothy A. Jones, EdD, RNC, FAAN*

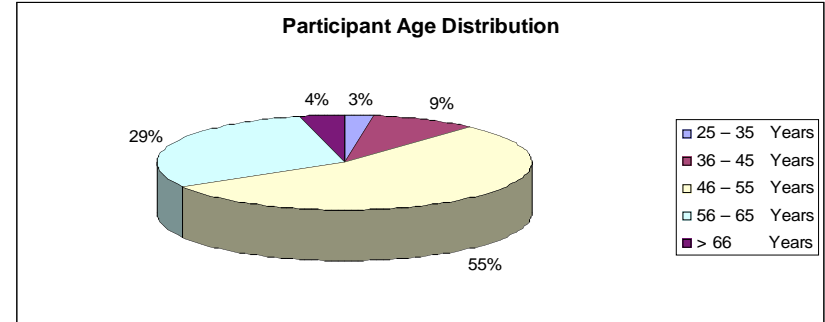
*Joyce C. Clifford, PhD, RN, FAAN*

**I. Section one of this document reports the demographic and conference attendance statistics.**

Typical survey respondents were 46-55 year old females from New England with a graduate nursing education. The majority of respondents (62%) held care delivery management roles as Vice President/ Chief Nursing Officer, Associate Vice President, Director or Manager primarily in hospitals and/ or medical centers (64%) in major metropolitan areas (65%). On average (53%), survey respondents had 5 years or less experience in their current employment position with 86% having less than ten years experience in their current role. Conference attendees represent membership in nearly fifty five different professional organizations and identified “applicability of topics to work” and “networking with other senior level nurses” among the most appealing reasons for attending the INHL conference. The following pages (Tables 1-15) provide more insight into the profile of the INHL conference attendees/ survey respondents.

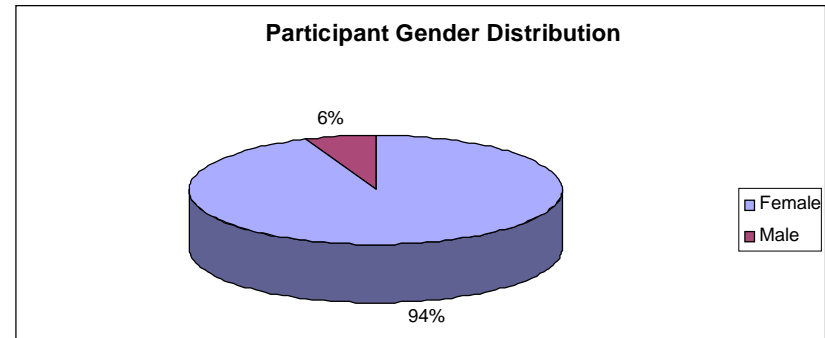
**Table 1: Participant's Age**

Participant's Age	Frequency	Valid Percent	Cumulative Percent
25 – 35 Years	2	3%	3%
36 – 45 Years	7	9%	12%
46 – 55 Years	43	55%	67%
56 – 65 Years	23	29%	96%
> 66 Years	3	4%	100%
	78	100%	



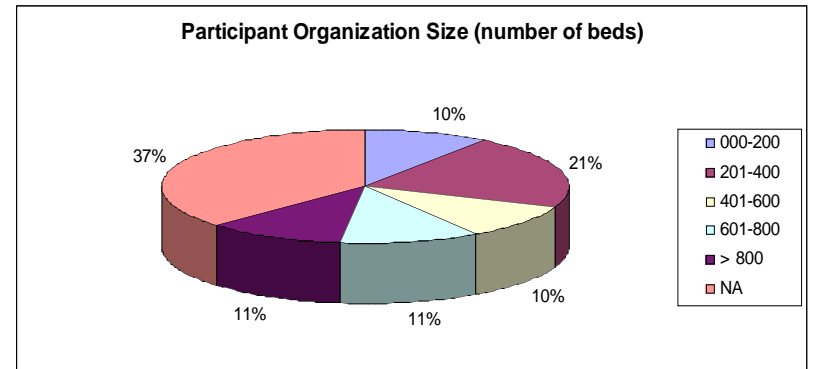
**Table 2: Participant's Gender**

Gender	Frequency	Valid Percent	Cumulative Percent
Female	75	94%	94%
Male	5	6%	100%
	80	100%	



**Table 3: Organization Size for Survey Respondents**

Organization Size	Frequency	Valid Percent	Cumulative Percent
000 – 200 Beds	8	10%	10%
201 – 400 Beds	17	21%	31%
401 – 600 Beds	8	10%	41%
601 – 800 Beds	9	11%	52%
> than 800	9	11%	63%
Not applicable	30	37%	100%
	80	100%	



**Table 4: Primary Title of Survey Respondents**

V.P./Chief Nursing Officer	18
Associate V.P.	6
Director	25
Manager	6
Dean/Faculty	15
Other	9
	79

**Table 5: Primary Employer of Survey Respondents**

Hospital or Health Care System	52
School of Nursing	18
Ambulatory Care	2
Healthcare Vendor or Consulting Group	2
Government Agency	2
Professional Membership Organization	4
	80

**Table 6: Employment Community**

	Valid Percent	Cumulative Percent
Major Metropolitan Area	65%	65%
Mid Sized City	18%	83%
Small City or Town	16%	99%
Sparsely Populated Rural Area	1%	100%
	100%	

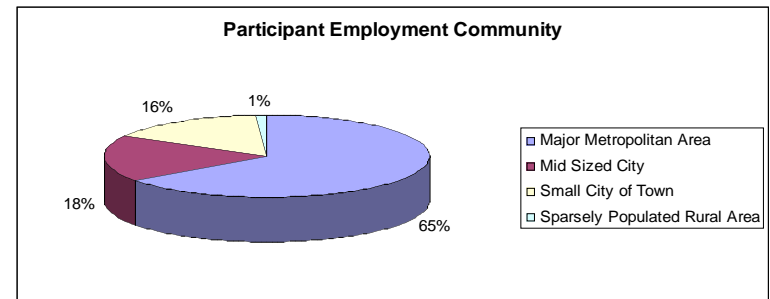
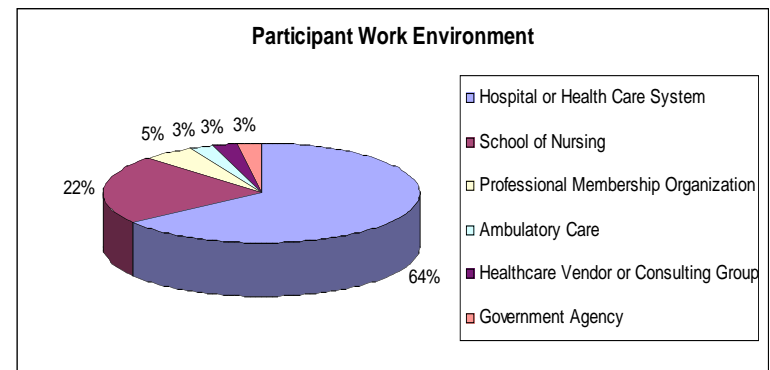
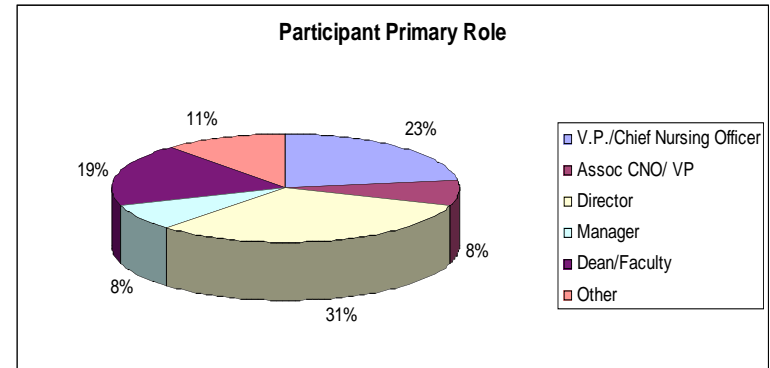
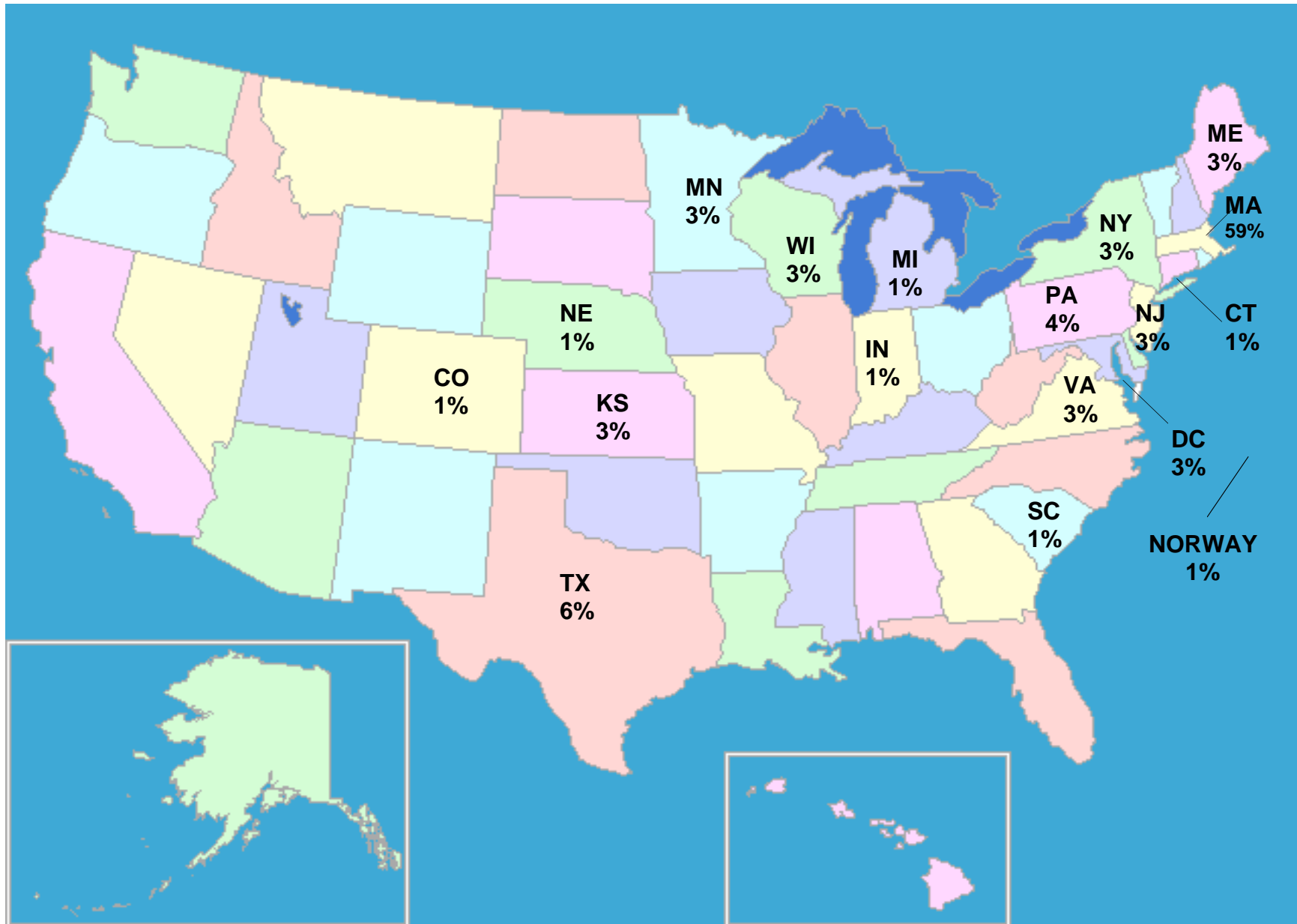
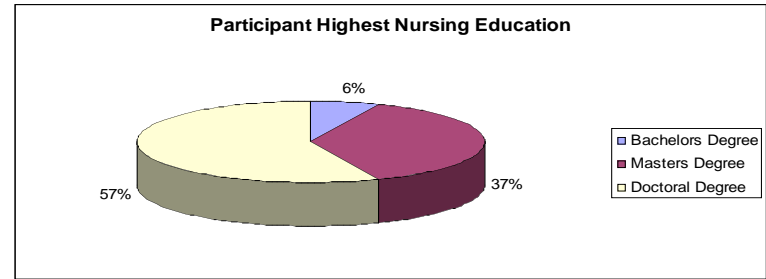


Figure 1: State of Respondent's Employment



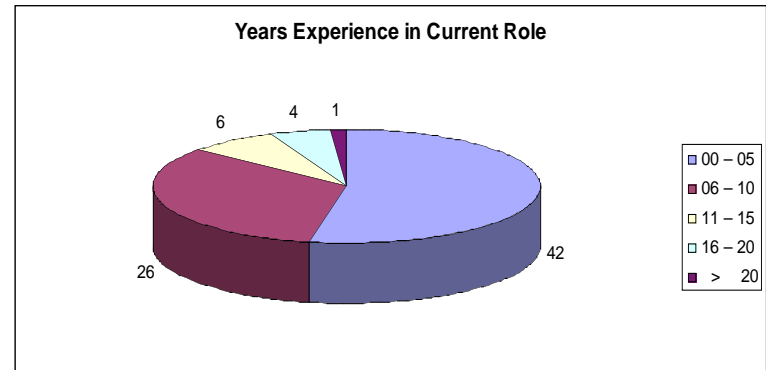
**Table 8: Highest Nursing Education Level**

	Frequency	Valid Percent	Cumulative Percent
Bachelors Degree	7	9%	9%
Masters Degree	41	52%	61%
Doctoral Degree	31	39%	100%
	79	100%	



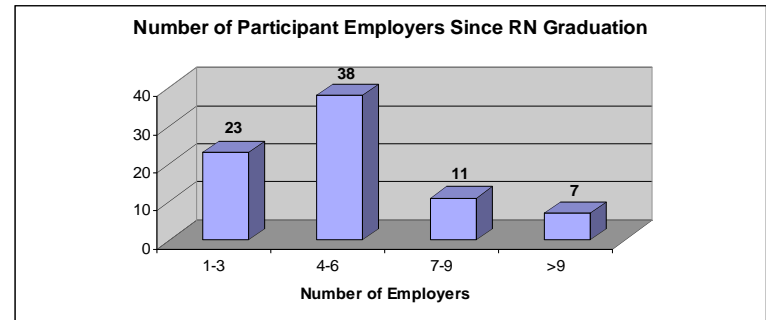
**Table 9: Years in Current Role**

	Frequency	Valid Percent	Cumulative Percent
00 – 05	42	53%	53%
06 – 10	26	33%	86%
11 – 15	6	8%	94%
16 – 20	4	5%	99%
> 20	1	1%	100%
	79	100%	



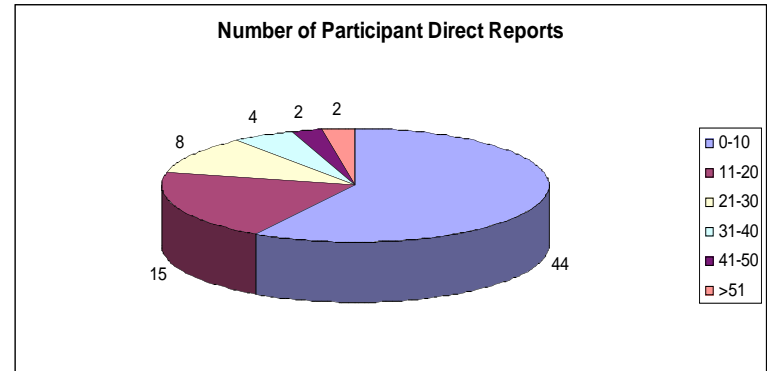
**Table 10: Number of Employers Since RN Graduation**

	Frequency	Valid Percent	Cumulative Percent
01 – 03 Employers	23	%	%
04 – 06 Employers	38	%	%
07 – 09 Employers	11	%	%
> 9 Employers	7	%	%
	79		100%



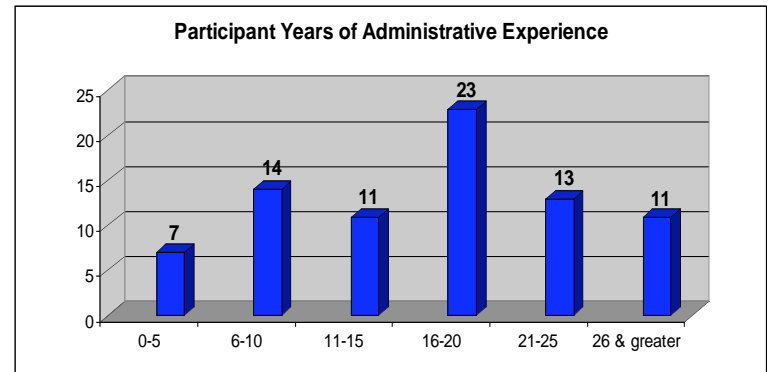
**Table 11: Number of Direct Reports**

	Frequency	Valid Percent	Cumulative Percent
00 – 10	44	58%	58%
11 – 20	15	20%	78%
21 – 30	8	11%	89%
31 – 40	4	5%	94%
41 - 50	2	3%	97%
> - 50	2	3%	100%
	75	100%	



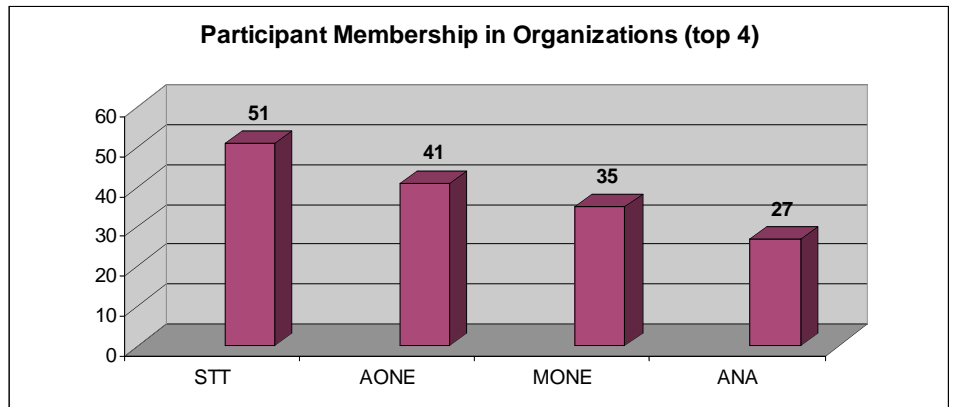
**Table 12: Participant Years of Administrative Experience**

	Frequency	Valid Percent	Cumulative Percent
Years: 0 - 5	7	9%	9%
Years: 6 - 10	14	18%	27%
Years: 11 - 15	11	14%	41%
Years: 16 - 20	23	29%	70%
Years: 21 – 25	13	16%	86%
26 and greater	11	14%	100%
	79	100%	



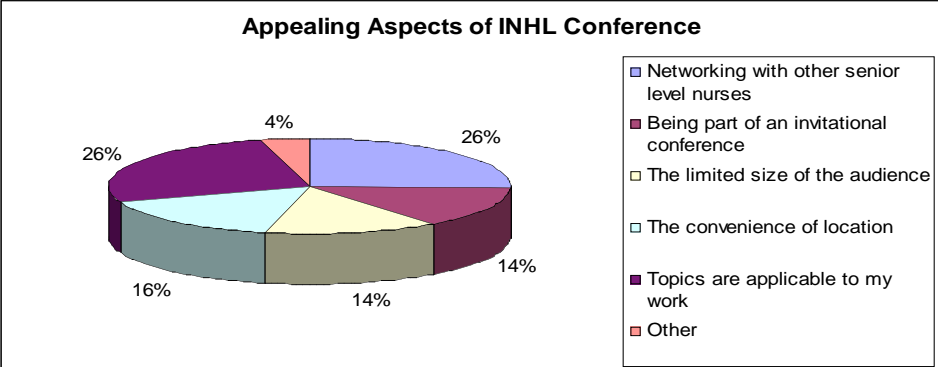
**Table 13: Top Four Professional Organizations of Respondents**

	Frequency
Sigma Theta Tau (STT)	51
American Organization of Nurse Executives (AONE)	41
Massachusetts Organization of Nurse Executives (MONE)	35
American Nurses Association (ANA)	27



**Table 14: Most Appealing Aspects of the INHL Conference**

Networking with other senior level nurses	66
Being part of an invitational conference	36
The limited size of the audience	36
The convenience of location	41
Topics are applicable to my work	69
Other (see comments below)	10



**Most Appealing Aspects of the INHL Conference – “Other” Comments**

*Reconnecting with colleagues...*

*Impressive speakers*

*Address critical issues/ challenges for nurse leadership in current practice*

*Speakers assume audience is sophisticated and advanced discussions happen*

*Added value. Don't find this experience anywhere else.*

*As an academic – this conference was extremely valuable because it updated me on practice issues and I will be able to diffuse the info through faculty and students.*

*Quality of speakers*

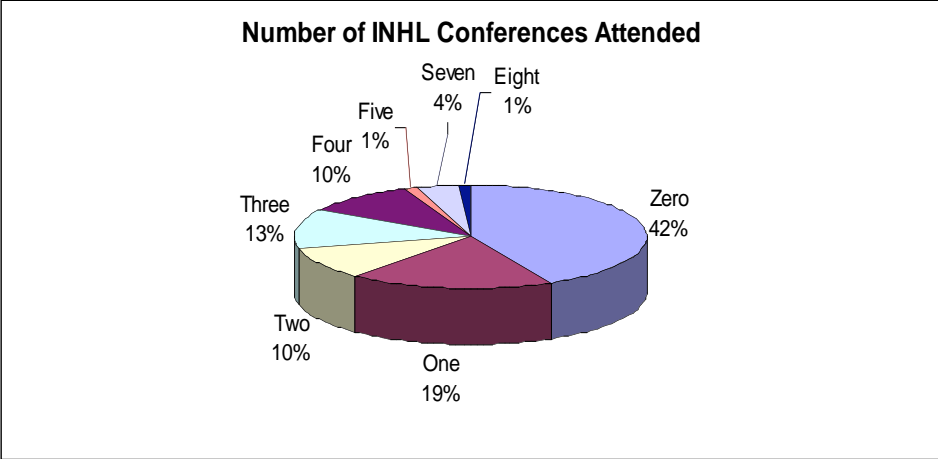
*Current research findings*

*Quality of the presentation and attendees are of a higher intellectual level – don't need to repeat the basics*

*Quality of faculty*

**Table 15: Number of INHL Conferences Attended**

	Frequency	Valid Percent	Cumulative Percent
Zero	34	42%	42%
One	15	19%	61%
Two	8	10%	71%
Three	10	13%	84%
Four	8	10%	94%
Five	1	1%	95%
Six	0	0%	95%
Seven	3	4%	99%
Eight	1	1%	100%
	80	100%	



**II. Section two of this document describes the primary themes identified by conference attendees when answering questions aimed at understanding how nurse executive leaders can and do maximize influence.**

Over 93% of the survey respondents wrote comments to the qualitative section of the survey. The four research questions aimed at nurse executive leadership strategies to maximize influence were evaluated using qualitative descriptive content analysis (Krippendorff, 2004; Sandelowski, 2000). The four most frequently identified themes and three verbatim response examples are listed. Five non-categorized non-thematic responses were also listed; these responses were identified as unique and may provide insight to nurse leadership best practices.

<b>RQ1: What methods/ strategies/ tools do you use to enhance interpersonal communication between you and those reporting to you?</b>	<b>RQ2: What methods/ strategies/ tools do you use to enhance knowledge and/ or competence amongst those reporting to you?</b>	<b>RQ3: Please describe the qualities and characteristics that you possess and use to enhance your interpersonal influence.</b>	<b>RQ4: What do you feel is the most effective means by which one can increase interpersonal influence within your organization?</b>
<b>Group Meetings</b> <ul style="list-style-type: none"> <li>• Retreats</li> <li>• Group retreats focused on achieving principles</li> <li>• Regularly organized staff meeting</li> </ul>	<b>Conference Funding Support</b> <ul style="list-style-type: none"> <li>• Education through, attendance at relevant conferences</li> <li>• Encourage conference attendance</li> <li>• Conference attendance</li> </ul>	<b>Trust</b> <ul style="list-style-type: none"> <li>• Work on trust relationships</li> <li>• Honesty...trust</li> <li>• Trustworthy and honest</li> </ul>	<b>Presence</b> <ul style="list-style-type: none"> <li>• Visibility</li> <li>• Show up, Make rounds</li> <li>• Presence - working collaboratively with staff to improve process</li> </ul>
<b>One on One Time</b> <ul style="list-style-type: none"> <li>• Face to face</li> <li>• biweekly 1:1 meetings</li> <li>• Individual monthly meeting</li> </ul>	<b>Journal Sharing</b> <ul style="list-style-type: none"> <li>• Journals</li> <li>• book &amp; article sharing</li> <li>• Encourage professional literature reading, provide 1-2 articles/month</li> </ul>	<b>Communicative/ Personable</b> <ul style="list-style-type: none"> <li>• Good social interpersonal skills</li> <li>• I am funny and put people at ease</li> <li>• Excellent communication skills</li> </ul>	<b>Key Relationships</b> <ul style="list-style-type: none"> <li>• Know the right people; get key people in power to support you.</li> <li>• Building and nurturing relationships</li> <li>• Maintain networks, even if difficult, build local coalition</li> </ul>
<b>Listening/ Presence</b> <ul style="list-style-type: none"> <li>• Listening-being truly present</li> <li>• Open door</li> <li>• Active listening</li> </ul>	<b>Formal Classroom Education</b> <ul style="list-style-type: none"> <li>• Support for enrollment in degree programs</li> <li>• Pay differential for advanced education</li> <li>• We also pay 100% tuition for nursing programs</li> </ul>	<b>Visionary</b> <ul style="list-style-type: none"> <li>• Vision of nursing fellow</li> <li>• Visionary</li> <li>• Vision of future</li> </ul>	<b>Message Articulation</b> <ul style="list-style-type: none"> <li>• Mean what you say, say what you mean, avoid mixed/hidden messages</li> <li>• Organized objectives &amp; communication</li> <li>• Setting clear outcomes</li> </ul>
<b>Written/ Telephone/ Email Update Communications</b> <ul style="list-style-type: none"> <li>• email updates are useful for sharing information and planning meetings</li> <li>• emails, telephone calls, handwritten notes especially for congratulations</li> <li>• Email</li> </ul>	<b>Role Modeling/ Mentoring/ Coaching</b> <ul style="list-style-type: none"> <li>• Mentoring, Mentor with experience on best way to handle situations</li> <li>• Leadership academy mentors</li> <li>• Personal coaching, group coaching</li> </ul>	<b>Emotionally Involved</b> <ul style="list-style-type: none"> <li>• Passion for nursing</li> <li>• Passion- its genuine and when I speak about patient care it comes from the heart</li> <li>• Genuine concern for patient care quality and professional satisfaction</li> </ul>	<b>Persistence</b> <ul style="list-style-type: none"> <li>• Strong work ethic</li> <li>• Tenacity around outcomes</li> <li>• being a good and caring colleague consistently over time, it takes time</li> </ul>
<b>Other responses of interest</b> <ul style="list-style-type: none"> <li>• Using a list of photographs to more easily link names to faces with large numbers</li> <li>• non traditional-blogs &amp; internet team sites</li> <li>• spatial proximity that enhances informal communication quick response that shows their communication matters</li> <li>• thorough explanations of all center activities</li> <li>• Humor, questions, invitations to visit and share ideas</li> </ul>	<b>Other responses of interest</b> <ul style="list-style-type: none"> <li>• Leadership academy mentors</li> <li>• I attend meetings, I provide a summary and make handouts available to faculty and staff</li> <li>• Set performance goals collaboratively</li> <li>• Opportunities to network</li> <li>• Retreats</li> </ul>	<b>Other responses of interest</b> <ul style="list-style-type: none"> <li>• Ability to bring diverse groups together to move towards common goal</li> <li>• Always seeking to learn and enhance current knowledge</li> <li>• Conflict management skills</li> <li>• I hold myself accountable for my actions and decisions</li> <li>• Timely responsiveness</li> </ul>	<b>Other responses of interest</b> <ul style="list-style-type: none"> <li>• Managing in a fiscally responsible way-finding opportunities to generate revenue</li> <li>• Personal reflection</li> <li>• Being an expert in what I do</li> <li>• Strong knowledge of current issues</li> <li>• Interdisciplinary shared governance</li> </ul>

## Discussion

The findings from this study and our previous INHL reports (Adams, Duffy, & Clifford, 2006; Adams et al., 2007; Adams et al., 2008) help to identify and understand the factors, attributes and process of influence within the nurse executive leadership population. Findings from RQ1 & RQ2 from the 2008 survey helped identify *tactics* or *interventions* nurse executive respondents use to influence increased communication and knowledge amongst those reporting to them. Findings from RQ3 and RQ4 helped to identify influence attributes possessed and valued by nurse executives to maximize influence. Findings from this 2008 study as well as the previous INHL conference survey studies have played a significant role in informing and validating the *influence factors, influence attributes* and *process of influence* as represented in the Adams Influence Model (AIM), as represented in Figure 2 (Adams, 2009).

The AIM was conceptualized with the intent to understand and define single issue influence as applicable to the nurse executive. The AIM was designed to represent a camera shutter. This was purposeful as the concept of interpersonal influence is a snapshot with the focus being on the four step core based on a singular issue.

The pattern at the core of the AIM involves;

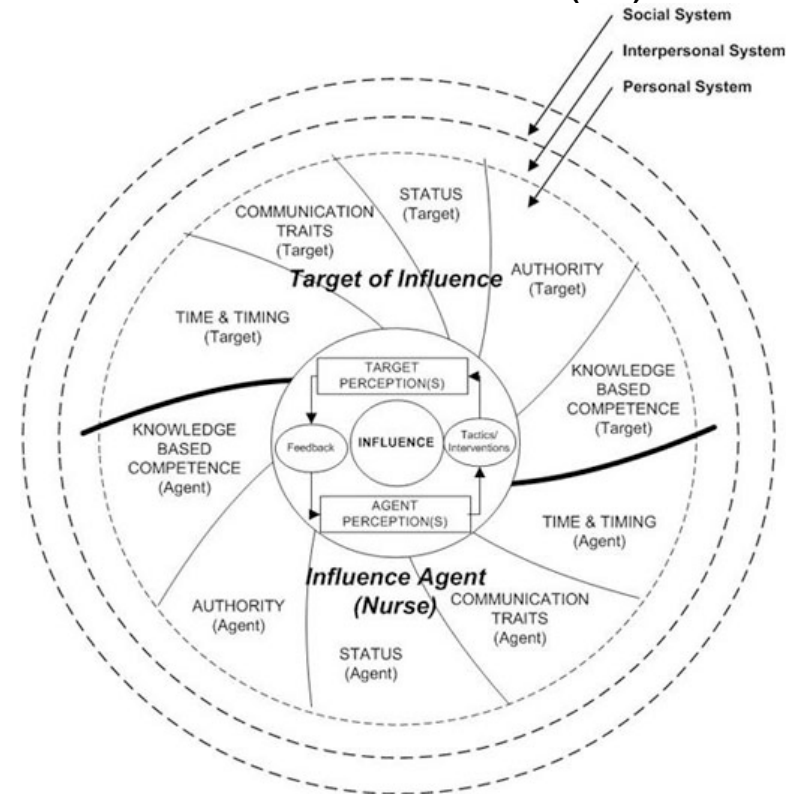
- 1) The Nurse (Influence Agent) perceiving the Target's collective influence factors
- 2) The Nurse (Influence Agent) choosing/ using tactics/ interventions to influence the Target
- 3) The Target perceiving the Nurse (Influence Agent's) collective influence factors
- 4) The Target giving feedback.

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 pattern as with each successive attempt, perceptions, time and knowledge change. If influence is achieved, the pattern ends for this particular issue.

The AIM represented in Figure 2, is an open-systems model. The importance of the open-systems model is simply representative of the interdependencies of the personal system, interpersonal system and social system (King, 1971; von Bertalanffy, 1968). The dotted line circles at the outside of the model 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 increasing the number of licenses for lobstering off the coast of Maine.

FIGURE 2: The Adams Influence Model (AIM)



Copyright © 2008 The Bogart Group, Inc.

## Discussion (continued)

*Influence factors* also contain subcategories or *influence attributes*. For example, the *influence factor - authority* is comprised of the *influence attributes – access to resources, accountability and responsibility*. It is important to note that 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. A complete list of the AIM's *influence factors* and associated *influence attributes* along with operational definitions can be found at [www.bogartgroup.com/adams\\_influence\\_model.html](http://www.bogartgroup.com/adams_influence_model.html).

The AIM was designed around single issue influence 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 airline pilot work scheduling. Single issue influence is also an important concept because the influence is often used incorrectly as a synonym to “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 airline industry.

Nursing leadership studies aimed at influence are extremely important. It has been identified that the application and understanding of influence begins with those tasked with motivating, securing support and resources (Yukl & Falbe, 1990), in no population is this more pertinent than within nursing leadership with the complexities of the workforce, changes to organizational budgets and the continued evolution of our healthcare system. 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 understanding how to focus individual efforts and maximize the continued influence of the discipline.

## REFERENCES

- Adams, J. M. (2009). *The Adams Influence Model (AIM): Understanding the factors, attributes and process of achieving influence* Saarbrücken, Germany: VDM Verlag.
- Adams, J. M., Duffy, M. E., & Clifford, J. C. (2006). *Knowledge and Influence of the Nurse Leader: A Survey of Participants from the 2005 Conference*. Boston, MA: Institute for Nursing Healthcare Leadership.
- Adams, J. M., Ives Erickson, J., Duffy, M. E., Jones, D. A., Aspell Adams, A., & Clifford, J. C. (2007). *Knowledge and Influence of the Nurse Leader: A Survey of Participants from the 2006 Conference*. Boston, MA: Institute for Nursing Healthcare Leadership.
- Adams, J. M., Paulo, L., Meraz-Gottfried, L., Aspell Adams, A., Ives Erickson, J., Jones, D. A., et al. (2008). *Success Measures for the Nurse Leader: A Survey of Participants from the 2007 INHL Conference*. Boston, MA: The Institute for Nursing Healthcare Leadership.
- King, I. M. (1971). *Toward a theory for nursing*. New York: John Wiley & Sons.
- Krippendorff, K. (2004). *Content Analysis: An Introduction to Its Methodology* (2 ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Sandelowski, M. (2000). Focus on research methods: Whatever happened to qualitative description? *Research-in-Nursing-and-Health*, 23(4), 334-340.
- von Bertalanffy, L. (1968). *General Systems Theory*. New York: George Braziller.
- Yukl, G., & Falbe, C. M. (1990). Influence tactics and objectives in upward, downward, and lateral influence attempts. *Journal of applied psychology*, 75, 132-140.

### Note from the lead investigator:

I would personally like to share my appreciation with all those that have participated in these INHL surveys over the past four years. I would especially like to thank Joyce Clifford, Jeanette Ives Erickson, Dorothy Jones and Linda Aiken for the access and direction in preparing the INHL conference surveys and subsequent reports. You have provided me wonderful opportunity and experiences as a doctoral student interested in understanding the nursing leadership population. -Jeffrey M. Adams PhD, RN