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# Applying the Adams Influence Model in Nurse Executive Practice

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The ability to influence others is a required competency for nurse executives trying to achieve positive patient/organizational outcomes. The Adams Influence Model (AIM) is a framework for understanding the factors, attributes, and process of influence. The AIM is grounded in nursing and organizational literature and provides nurse leaders with a road map for developing an effective strategy to achieve influence with individuals and/or groups. The authors describe the AIM and present a case study illustrating its application by a chief nurse executive.

Influence, or the ability of an individual to sway or affect another person or group, is critical to the chief nurse executive (CNE) role. Influence is a key determinant affecting decision making and is essential for motivating colleagues and staff, securing required support, and procuring adequate resources.[1] The importance of nurse leaders' influence on professional practice/work environments and patient and organizational outcomes has been well described in the literature.[2,3] In addition, the American Organization of Nurse Executives identifies influence behaviors as an essential component of nurse executive competency,[4] and the American Nurses Association identifies the distinct spheres of nurse administrator influence in its recently released *Scope and Standards for Nursing Administrators*.[5] A poll conducted among leaders in industry, academia, and government by Gallup, Inc, and the Robert Wood Johnson Foundation in 2010, however, emphasized the limitations of nursing influence.[6] Although the Gallup poll's respondents believed nurses have a great deal of influence on efforts to reduce medication errors and improve care quality within health systems, they ranked nurses last—after the government, insurance and pharmacy executives, doctors, and patients—among those likely to influence health reform in the United States.

Although most nurse leaders recognize the importance of influence and its role in effecting change, many are less familiar with how influence is acquired, enhanced, and strategically applied. This gap in understanding is highlighted by studies in which nurse leaders self-identified themselves as less knowledgeable and influential than nonnurse healthcare executives within their organizations.[7,8] The Adams Influence Model (AIM) provides CNEs with a road map for understanding the factors, attributes, and process of influence and can be used by nurse leaders as a guide to maximizing their individual influence and that of the profession.

## The Adams Influence Model

The development of the AIM was prompted by observations of nurse leaders and the varying degrees of success they experienced when attempting to influence decisions within their organizations. After an extensive review of the nursing, psychology, and organizational studies literature, the AIM's developer created an initial influence model. This model was refined and improved over a 5-year period based

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on content-validating dialogue and pilot testing with CNEs and nurse researchers and a content validation study involving nurses and other clinicians overseen by CNEs.[9]

The AIM was developed with a focus on nurse leaders, making it unique among influence models. It is based on the following operational definition: Influence is the ability of an individual (agent) to sway or affect another person or group (target) about a single issue based on authority, status, knowledge-based competence, communication traits, and/or use of time and timing.[9] As described below, each of the elements in this definition are reflected in the AIM.

The graphic representation of the AIM (Figure 1) resembles a camera lens, emphasizing the model's focus on a particular "snapshot" moment in time and its conceptualization of influence within the context of a single issue. This conceptualization recognizes that a person's influence varies depending on the issue[10] and distinguishes influence from power, which results from being influential over many issues and/or across multiple domains.

### Influence Agent and Target

The AIM underscores the interpersonal nature of the influence process. Among nurse leaders, influence generally involves 2 people within a larger system: the influence agent, or nurse leader who is attempting to sway another person, and the influence target, or the person (or in some cases the group) who is the focus of these efforts. The interplay between these 2 individuals is represented in the circle that forms the AIM's core. When trying to achieve influence, the nurse leader as "influence agent" typically chooses to use 1 or more interventions or tactics. Tactics used might include seeking and obtaining approval and support from other individuals, offering implicit or explicit rewards, making an emotional request or proposal, building coalitions, using logic and rational persuasion, or collaborating with the influence target.[1] Which tactics nurse leaders use depends on the perceptions they have of themselves, the target, the issue, and potentially the feedback they receive from the target. The tactics that are used also depend on whether the influence effort is directed at someone viewed as a superior, a situation referred to as upward influence, an equal (lateral influence), or as a subordinate (downward influence).[11] In a small pilot study, Adams[12] ("Influence Model for the Female Executive" [unpublished study]; Ann Arbor, MI; University of Michigan School of Nursing; 2003) found that rational persuasion and coalition building are the influence tactics most favored and used by female healthcare executives.

### Influence Factors and Attributes

The AIM also identifies factors that affect nurse leaders' efforts to influence others. These factors, arrayed around the model's core, impact the influence agent as well as the target and include authority, communication traits, knowledge-based competence, status, and use of time and timing. Each factor has specific attributes (Table 1), which describe the factor's dimensions and how it is manifested in practice. For example, attributes associated with the factor, status, include an individual's hierarchical and informal position, key supportive relationships, and reputation. Both the influence agent and the target can "titrate" these factors, depending on the issue, emphasizing or deemphasizing a particular factor if they believe it will help their effort to achieve or fend off an influence attempt. For example, when trying to influence the chief executive officer (CEO), a CNE might rely on their knowledge-based competence surrounding an issue rather than emphasizing their organizational status. Conversely, in trying to resist an influence attempt, CEOs might place more emphasis on their status as the organization's leader. It is important to note, however, that in most cases it is the amalgam of influence factors and attributes, rather than any single factor, that helps nurse leaders successfully achieve influence.

### Personal, Interpersonal, and Organizational Systems

The outer boundary of the AIM is composed of 3 rings, which indicate how influence is affected by personal, interpersonal, and social systems. For example, an attempt to influence another might be bolstered by persistence, a possible element of one's personal system, or by a personal history between the agent and target (an element of the interpersonal system) or the organizational culture (an element of the social system). The rings are drawn with dotted lines to highlight the AIM's open system framework[23] and the fluid interrelationship that exists among these 3 systems and the other model components.

As highlighted by the AIM, influence is both a reflective and a dynamic process. When trying to influence others, nurse leaders must carefully reflect on and consider the various factors and personal, interpersonal, and social systems that impact themselves and the persons they are trying to influence and choose their influence tactics accordingly. In some cases, an attempt to influence others might meet with immediate success. When it does not, the nurse leader can begin the process again, informed by feedback and new perceptions and potentially using new tactics.

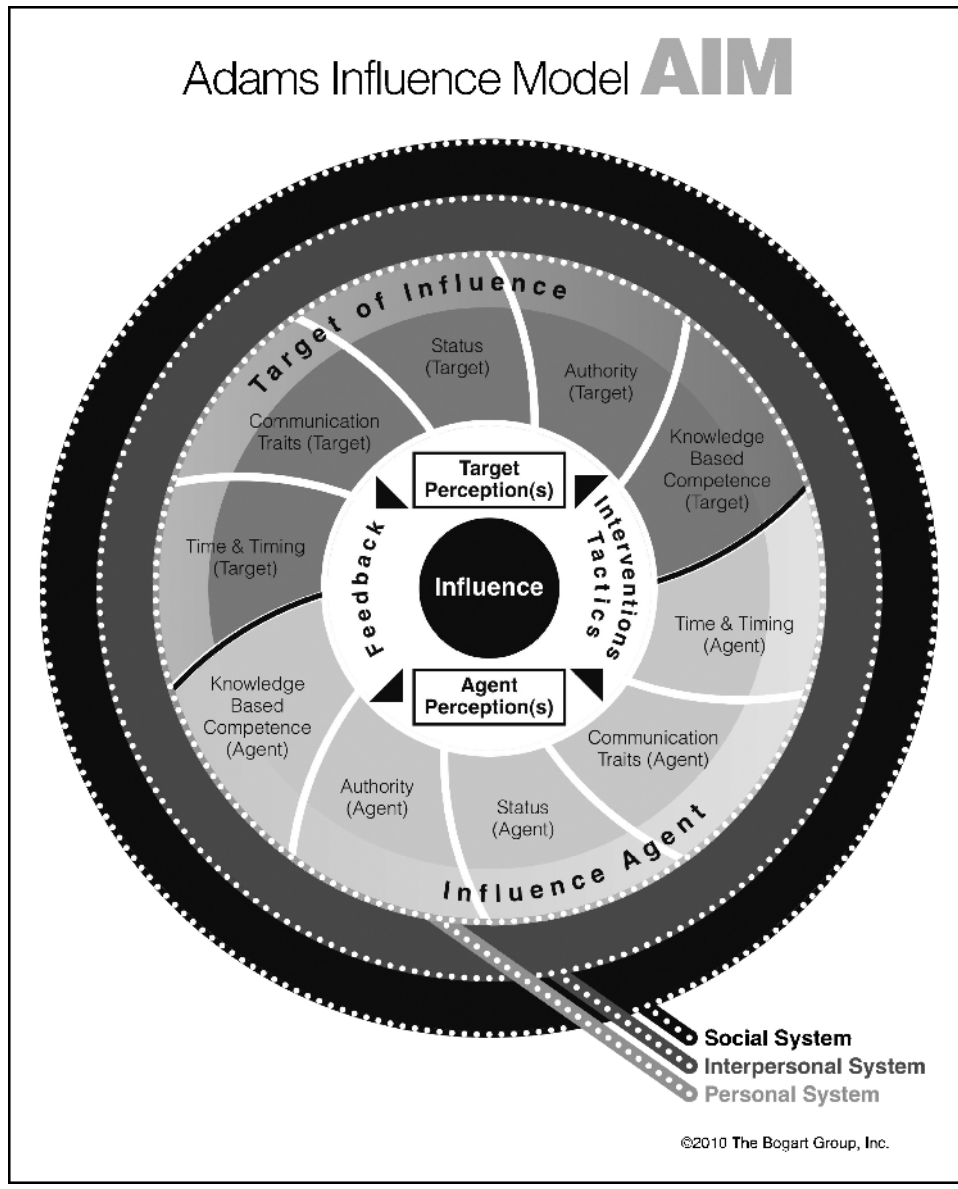


Figure 1. Adams Influence Model.

Many of the issues confronting CNEs are highly complex, reflecting the complicated nature of today's healthcare organizations and the intricacies of providing patient care. The following example illustrates how the AIM can be useful in helping CNEs address some of their most daunting challenges and use their influence to help reshape an organization in fundamental ways.

## *Applying the AIM in Practice: A Case Example*

Massachusetts General Hospital is a 907-bed, academic medical center that has been formally recognized as a Magnet® institution since 2003. The organization has long prided itself on its systems to ensure patient safety; however, in 2010, an incident occurred that caused the entire institution to call those systems into question. The incident involved a surgical patient on a general medical-surgical unit who was found unresponsive and without a pulse by a clinical nurse. The nurse immediately began cardiopulmonary resuscitation and called a code. Unfortunately, the resuscitation efforts were unsuccessful, and the patient died. Immediately after the event, the nurses began to question why the patient's heart monitor alarm had not alerted them to the patient's deteriorating condition. Investigating the situation, they were devastated to learn that

the monitor alarm had been inadvertently turned off, and as a result, the patient's condition went undetected for several minutes.

This event was the source of great distress for everyone in the organization, from senior leaders to every direct care provider. Immediately after learning of it, the CNE initiated a more detailed investigation as well as preliminary corrective actions. The patient's family was informed of the details of the event, and within 6 hours, the alarm off-switch was disabled on every monitor in the hospital (1,100 monitors in all), so that such an event could not happen again. In addition, a communication and education plan was developed and implemented to inform all

***Table 1.*** *Adams Influence Model: Influence Factors and Attributes*

| Influence Factors | Operational Definition | Influence Attributes | Operational Definition |
|---|---|---|---|
| Knowledge-based competence | The quality of being adequately or well qualified intellectually so as to meet or exceed standards of performance[13] (competence) | Empirical knowledge | The application of theories of science; factual knowledge of nursing, the scientific body of nursing knowledge[14] |
| | | Personal knowledge | Providing means to become more aware of culture, customs, beliefs, and emotions[14] |
| | | Aesthetic knowledge | Envisioning desired outcomes to respond with appropriate action; it is creative, open, empathetic, and holistic[14] |
| | | Ethical knowledge | The capacity to make choices within situations to make moral judgments; ethical knowing is expressed in codes, standards, and ethical frameworks[14] |
| | | Sociopolitical knowledge | Some sociopolitical areas that affect the health of the population are class structure, poverty, sexism, racism, etc[15] |
| Authority | The right to take actions or responsibility[16] | Accountability | The state of being liable, or answerable[16] (accountability) |
| | | Responsibility | The social force that binds you to the courses of action demanded by that force[13] (responsibility) |
| | | Access to resources | Ability to manage or oversee finances, information, or goods that are needed or valued by others[17] |
| Status | Having high standing or prestige[13] (status) | Hierarchical position | An organized body of officials in successive ranks or orders[13] (hierarchy, position) |
| | | Key supportive relationships | An emotional or other connection between people[13] (relationship) |
| | | Reputation | A favorable and publicly recognized name or standing for merit, achievement, reliability[13] (reputation) |
| | | Informal position | An assumed or appointed role and the related pattern of expected interpersonal behaviors based associated with the role[18] |
| Communication traits | The proficiency or dexterity with which one relates or interacts with individuals | Message articulation | The shape or manner in which things come together and a connection is made[13] (articulation) |
| | | Emotional involvement | To engage the interests or emotions or commitment of[13] (involvement) |
| | | Persistence | The act of persevering; continuing, or repeating behavior[13] (persistence) |
| | | Confidence | Belief in oneself and one's powers or abilities[13] (confidence) |
| | | Physical appeal, self | The attractiveness of the individual[19,20] |
| | | Physical appeal, environment | An expected order to one's surroundings[21] |
| | | Presence | Being with another, both physically and psychologically, during times of need[22] |
| Use of time and timing | | Amount of time to sell an issue | A limited period or interval, as between 2 successive events[13] (time) |
| | | Timing to deliver the issue | The selecting of the best time or speed for doing something to achieve the desired or maximum result[13] (timing) |

hospital staff of the situation and outline the organization's response.

Although the CNE could have ended her involvement at this point, she knew this tragic event and the organization's employees merited a deeper response, one focused on redefining how the institution prepared for, responded to, and ultimately sought to prevent adverse events in the future. She was determined to lead this effort. However, to do so, she first had to gain a deeper understanding of the current event and prepare a plan to influence all of her constituencies—superiors, peers, and subordinates—about the value of rethinking the organization's response to adverse events in the moment and the longer term. Her influence strategy drew on each of the influence factors identified by the AIM: authority, knowledge-based competence, time and timing, communication traits, and status.

One of the CNE's first actions involved defining her authority over the current crisis by claiming accountability for the state of systems that contributed to the event and responsibility for improving their performance. She stated her accountability repeatedly, in meetings with hospital leaders, chiefs, and staff, and during an interview with a reporter covering the story for a local paper. By assuming authority and accountability for the event, the CNE was able to influence its interpretation, framing it as a system failure rather than the failure of an individual, and positioned herself to play a role in guiding next steps.

The CNE also took steps to enhance her knowledge-based competence. In addition to developing a broader understanding of physiological monitoring and related clinical decision making, she began investigating best practices for responding to adverse events and strengthening an organization's culture of safety. She reacquainted herself with human factors theory, which suggests that human behavior, abilities, limitations, and other characteristics must be considered in the design and utilization of tools, machines, systems, tasks, jobs, and environments to ensure their productive, safe, comfortable, and effective use by humans.[24] In addition, she networked with experts and colleagues at other institutions who had experience implementing a systems-based approach to managing errors and promoting patient safety in a transparent, proactive, and patient-centered manner. By deepening her empirical knowledge and becoming fluent in the approaches, issues, and language associated with error management and patient safety, the CNE was able to introduce and influence thinking and dialogue on the topic among leaders of the organization.

The CNE's use of time and timing and her style of communication were also key to her efforts to influence others. Instead of letting time pass, the CNE immediately began speaking with the CEO and other senior leaders about the importance of reexamining the hospital's approach to patient safety and adverse events. Addressing the issue promptly after the patient's death allowed the CNE to tap into other leaders' sense of urgency and receptivity to change. By assuming accountability and identifying the event as an opportunity for change, she communicated confidence; by reaching out to the nurses, offering them support, and sharing her own anguish about the event, she communicated her emotional involvement; and by discussing the event and her thoughts about next steps at leadership meetings, with trustees and chiefs, and at open forums, she communicated commitment and persistence. In addition, she consistently used a systems perspective to frame the event and the required next steps, thus laying the groundwork for rethinking the organization's approach to error management.

Undeniably, the CNE's status was a critically important factor and greatly enhanced her ability to influence others. In her 14 years as a CNE, she had developed strong connections and supportive relationships with other members of the executive team and acquired a reputation for relentlessly pursuing excellence and encouraging innovation. Her CEO and executive peers knew she would bring these same qualities to a reexamination of patient safety and error management processes. The CNE's efforts to convince others that such a reexamination was in order were also bolstered by the organization's social system and culture. Patient safety was a top priority for the institution, and the hospital routinely sought out and incorporated best safety practices. Even as the tragedy was unfolding, leaders and staff at every level were open to learning how it might help them improve their approach to patient safety and error management.

The CNE's efforts to influence her constituencies about error management and prevention were successful. The CEO and the CNE's peers and subordinates agreed that the current tragedy represented a system failure and that it created a mandate and opportunity to reevaluate the organization's approach to patient safety and error prevention. Soon after the tragic event occurred, the CEO appointed the CNE to lead the reevaluation effort.

## Discussion

As illustrated by the case study, the AIM provides CNEs and other nurse leaders with a useful framework for understanding, articulating, and using influence to achieve positive outcomes. By conceptualizing

influence within the context of a single issue, the AIM helps nurse leaders narrow their focus and develop clear goals for their influence efforts. In the case study, the CNE focused efforts on persuading the organization to reexamine its approach to patient safety and error management and having the CEO appoint her to lead this work. Her approach illustrates how each of the influence factors defined by the AIM individually and collectively contributes to influence efforts and achievement. By bolstering her knowledge-based competence and skillfully titrating the factors of time and timing, authority, and communication, the CNE established ownership over the immediate crisis and was positioned to influence the organization's approach to error prevention in the longer term. By capitalizing on her well-established status and track record, the CNE was able to best position herself for leadership of this longer-term effort.

The AIM may be especially useful to nurse leaders entering new organizations or assuming new roles. When an organization and its individuals are familiar, the process of influencing others can become intuitive. For those entering new organizations and roles, the AIM can serve as a reminder about the factors, attributes, and systems that should be taken into consideration when developing an influence strategy and serve as a road map for assessing how these variables impact themselves as influence agent, the influence target, and the situation.

Although the importance of influence is widely understood, influence is a subject that is rarely explored as part of nursing education and nursing leadership programs. Thus, nurse leaders who mentor and coach others can find it difficult to describe the influence process and guide their mentees' influence efforts. With its grounding in nursing leadership practice as well as the nursing, psychology, and organizational studies literature, the AIM provides a valuable and validated tool for nurse executives to examine and understand influence, helping them focus their efforts to achieve desired outcomes across practice, education, policy, and research.

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