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PERSONNEL'S READINESS FOR CONTINUOUS QUALITY IMPROVEMENT IN COMMUNITY HOSPITALS IN NAKHONCHAISI DISTRICT, NAKHONPATHOM PROVINCE

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อภินันทนาการ
จาก
บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล

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PUNNIPA CHUENKLINTOOP : PERSONNEL'S READINESS FOR CONTINUOUS QUALITY IMPROVEMENT IN COMMUNITY HOSPITALS IN NAKHONCHAISI DISTRICT, NAKHONPATHOM PROVINCE. THESIS ADVISORS : JIRAPORN SAWANGNETR,Ph.D.,SOMSAK SONGSAMPHANT, M.P.A.,YUNYONG AMPAWA , M.S.,THAWATCHAI CHAIJIRACHAYAKUL Ph.D., 135 p. ISBN 974-04-0289-5.

All community hospitals in NakhonChaisi district, NakhonPathom province are improving their standard to receive accreditation , with an ultimate goal to provide high quality service. A study of personnel's readiness for continuous quality improvement in community hospitals resulted in an understanding of the readiness of personnel ,both the executive committees and the operational officials. It also showed the factors influencing personnel's readiness for quality improvement as well as the obstacles in the quality improvement process. This study was conducted by the survey research method. The studied population was 191 government officials working for 3 community hospitals, namely Huayplu Hospital, Luangporpern Hospital and Nakhonchaisi Hospital. The data were gathered by questionnaire and then analyzed by the SPSS program. Arithmetic mean , percentage , standard deviation , t-test, one way ANOVA , and stepwise multiple regression analysis were employed in this study.

It was found that both the executive committee and the operation officials were at an average level of readiness for quality improvement. The executive committees were more ready than the operational officials at a 0.05 level of statistical significance. Community hospitals ,with different characteristics of leadership and organizational culture, were different regarding the personnel's readiness at a statistical significance of 0.05. Seven variables had an influence on personnel's readiness : organization culture, high level and average level of perception in quality improvement of information, leadership, educational level, marital status(married), and type of personnel (nurses). The seven variables can also predict about 66.1 % of changes in personnel's readiness. The obstacles to improvement were insufficient training for personnel, that the process is not continuous, that it lacks participation from every level of personnel, that most officials do not really understand quality improvement, and that the policy cannot be effectively conveyed to the operational officials.

This study suggests that there should be changes in the organizational culture of hospitals , particularly in the areas of teamwork, participation of personnel at every level, and the vision of organizers. Hospitals should also be open to independent evaluation and patient evaluation of the services provided.

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พัณณิภา ชื่นกลิ่นธูป :ความพร้อมของบุคลากรในการพัฒนาคุณภาพโรงพยาบาลชุมชนในเขตพื้นที่อำเภอนครชัยศรี จังหวัดนครปฐม(PERSONNEL'S READINESS FOR CONTINUOUS QUALITY IMPROVEMENT IN COMMUNITY HOSPITALS IN NAKHONCHAISI DISTRICT, NAKHONPATHOM PROVINCE.) คณะกรรมการควบคุมวิทยานิพนธ์ : จิราภรณ์ สว่างเนตร, พบ.ด., สมศักดิ์ ส่งสัมพันธ์, M.P.A., ยรรยงศ์ อัมพวา, วท.ม.(ชีวสถิติ)., ธวัชชัย ชัยจิรฉายากุล, Ph.D(Curriculum & Foundation of Education). 135 หน้า. ISBN 974-04-0289-5

โรงพยาบาลชุมชนในเขตพื้นที่อำเภอนครชัยศรี จังหวัดนครปฐม ต่างกำลังเร่งดำเนินการพัฒนาคุณภาพ เพื่อมุ่งสู่การรับรองคุณภาพโรงพยาบาล โดยมีเป้าหมายสูงสุด คือ การให้บริการที่มีคุณภาพแก่ประชาชน การศึกษาเรื่องความพร้อมของบุคลากรในการพัฒนาคุณภาพโรงพยาบาลชุมชนจะทำให้ทราบถึงระดับความพร้อมของบุคลากรทั้งระดับผู้บริหาร ระดับผู้ปฏิบัติ และเข้าใจถึงปัจจัยที่มีอิทธิพลต่อความพร้อมของบุคลากรในการพัฒนาคุณภาพรวมถึงปัญหาอุปสรรคในการดำเนินการพัฒนาคุณภาพโรงพยาบาลชุมชน ดำเนินการศึกษาโดยการวิจัยเชิงสำรวจ(Survey Research) กลุ่มประชากรที่ศึกษาเป็นข้าราชการและพนักงานของรัฐทั้งหมดที่ปฏิบัติอยู่จริงในโรงพยาบาลชุมชน 3 แห่ง ได้แก่ โรงพยาบาลห้วยพลู โรงพยาบาลหลวงพ่อเปิ่น โรงพยาบาลนครชัยศรี จำนวน 191 คน เก็บรวบรวมข้อมูลโดยใช้แบบสอบถาม และวิเคราะห์ข้อมูลด้วยโปรแกรมสำเร็จรูป SPSS สถิติที่ใช้ คือ ค่าเฉลี่ย ค่าสถิติร้อยละ ส่วนเบี่ยงเบนมาตรฐาน t-test , One-Way ANOVA และการวิเคราะห์การถดถอยพหุแบบเป็นขั้นตอน

ผลการวิจัยพบว่า บุคลากรทั้งระดับผู้บริหาร และระดับผู้ปฏิบัติ มีความพร้อมในการพัฒนาคุณภาพอยู่ในระดับปานกลาง โดยระดับผู้บริหารมีความพร้อมสูงกว่าระดับผู้ปฏิบัติอย่างมีนัยสำคัญทางสถิติที่ระดับ 0.05 และโรงพยาบาลชุมชนที่มีความแตกต่างในลักษณะผู้นำองค์การ ลักษณะวัฒนธรรมองค์การ จะมีผลทำให้บุคลากรมีความพร้อมในการพัฒนาคุณภาพแตกต่างกันอย่างมีนัยสำคัญทางสถิติที่ระดับ 0.05 โดยลักษณะวัฒนธรรมองค์การ การได้รับข่าวสารการพัฒนาคุณภาพในระดับมาก การได้รับข่าวสารการพัฒนาคุณภาพในระดับปานกลาง ลักษณะผู้นำองค์การ ระดับการศึกษา สถานภาพสมรส(คู่) ประเภทบุคลากร(กลุ่มพยาบาล) มีอิทธิพลในเชิงบวกต่อความพร้อมของบุคลากร และสามารถร่วมกันทำนายการเปลี่ยนแปลงความพร้อมของบุคลากรในการพัฒนาคุณภาพโรงพยาบาลชุมชนได้ร้อยละ 66.1 และการศึกษานี้ยังพบว่า ปัญหาอุปสรรคในการดำเนินการพัฒนาคุณภาพโรงพยาบาลชุมชนที่สำคัญ ได้แก่ บุคลากรได้รับการฝึกอบรมไม่เพียงพอ ขาดความต่อเนื่องในการพัฒนาคุณภาพ ขาดการมีส่วนร่วมของเจ้าหน้าที่ทุกระดับ เจ้าหน้าที่ส่วนใหญ่ยังไม่เข้าใจเรื่องการพัฒนาคุณภาพดีพอ รวมถึง การถ่ายทอดนโยบายการพัฒนาคุณภาพสู่ระดับผู้ปฏิบัติไม่มีประสิทธิภาพเท่าที่ควร

ข้อเสนอแนะจากการวิจัย มีประเด็นที่สำคัญ คือ การปรับเปลี่ยนวัฒนธรรมองค์การ โดยผู้บริหารระดับสูงต้องมีวิสัยทัศน์ มีความมุ่งมั่นในการปรับเปลี่ยนวัฒนธรรมองค์การ เน้นการกระจายอำนาจการตัดสินใจลงสู่ผู้บริหารระดับล่าง และทีมงาน ทำให้ทุกคน ทุกส่วน และทุกหน่วยงาน มีส่วนร่วมรับผิดชอบและตัดสินใจแก้ปัญหาร่วมกัน และที่สำคัญต้องสร้างระบบประเมินผลแบบเปิด ให้ประชาชนและผู้รับบริการเข้ามามีส่วนร่วมในการตรวจสอบ ประเมินผล การให้บริการของโรงพยาบาล

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CHAPTER I
INTRODUCTION

1.1 History and Importance of the Problem

In the globalization era, changes happen rapidly and result in various effects which cause changes in every section, both governmental and private ones. There may be absolute improvement in the country's production and services in order to prepare itself for those changes. The health affairs are now changing as well, and the most important one is the acts on national health to function as the nation's health laws. It is considered a declaration on health affairs in the Thai society. Moreover, the acts on health affairs will assign the system and the main structure in order to revolute the national health affairs systematically and concretely on the basis of health revolution that building up good health is better than curing the diseases. Additionally, it is necessary to establish the health system with efficiency, quality and morality, which can response the social needs, necessity and expectation (Pongsatorn Pogpermdee, 2000:2). This is to set up the health service with coverage and equity in which people can undergo the services, quality, efficiency and accountability (Sunee Suksawang, 2000:6). It can be said that the ultimate goal of health system revolution is that Thai people have good health, that they don't get sick or die unnecessarily, that diseases can be controlled and they are not spread in the society. Moreover, Thai people can undergo the qualitative health services thoroughly. The health system must, therefore, contain quality, efficiency and equity for everybody.

Hospitals are a part of the health service which must accredit the society that they would operate with quality, efficiency and equity. This role is expected by the society, and it is also assigned in the Constitution of the Kingdom of Thailand in 1997 that people are equal to undergo the qualitative health service, and that the poor can undergo the service from the governmental health clinics without payment, according to the item 52. The government, furthermore, must set up and support the health

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service so that people can use them with quality and efficiency, according to the item 82. Quality, accordingly, concerns people's or consumers' rights, according to the Constitution , social trend and the national economic and social improvement plan. It is also accepted worldwide and improved, especially for the governmental hospitals (The Institute of Hospital Accreditation , 2000:3).

In Thailand, the approach on quality improvement is introduced and adapted to improve the health service places continuously. It appeared vividly in the seventh national health affairs improvement plan (1992 - 1996) that all service places must be improved (The Association of Public Health of Thailand, 1995:8). In accordance with this policy, the Ministry of Public Health declared the functional methodology, with an emphasis on changing the health service places into quality which is considered an essential strategy in order to please the customers and response the professional standard in 1995 (Witoon Saengsingkaew, 1995:2). During 1993 - 1996, the World Health Organization, the Institute of Public Health Research and the Local Hospital section established the research and improvement project by employing the TQM (Total Quality Management) in the 8 sampling hospitals in the Ministry of Public Health. Later, in 1997, the Ministry of Public Health, together with the health affairs system research institute and the research fund office set up the project on improvement and hospital accreditation (HA) with thirty five experimenting hospitals which applying for the project willingly. At present, it is improved from the project on hospital accreditation to the Hospital Accreditation Institute . The members of this institute comprise of the experts, the academic persons, the professional organization, the consumer representatives and mass media groups. They set up the methodology, the goal and the motto together in order to improve and accredit the hospitals' quality. Hospital Accreditation Institute would function practically, then, so that accrediting the hospitals' quality would be trustworthy and acceptable among the Thai.(Anuwat Suppachutikul, 2000:1-4)

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Hospital Accreditation is a sort of confirming success on quality improvement from outside organizations that the hospitals' services are as good as the national standard. It is the process which various countries all over the world employ as a stimulant for accreditation of the health service places thoroughly, especially the hospitals. The World Health Organization (WHO) also utilizes it as a method for operational improvement and continuous quality one (Jiroot Srirattanaball, 2000:2). Consequently, accreditation in the hospitals is the main trend in quality improvement of the health service places. However, it is only a tool, not the goal because the exact goal is high quality services.

To be accredited, a success on quality improvement, the hospitals must prepare the personnel, encourage them to cooperate. They must establish the organization's plans together, improve the working methodology systematically, look for the measure and facilities, activate the quality improvement activities, evaluate the project and develop it until it can be certain that it approaches a level of quality improvement. Then, the experts or the outside organizations are invited in order to analyze and confirm the success on that improvement (Anuwat Suppachutikul, 1998:2).

Presently, business is quite competitive, and it is called business war or customer war. Quality is then the essence which can make one win in the competition. In another word, quality is the organization's survival. Hospitals, both of the government and of the private, compete one another in order to upgrade themselves to approach the standard of the hospital accreditation, therefore. They want the society to recognize that they are trustworthy, people to trust in them that the patients will receive good services, not take risks in treatment. Moreover, the professional organizations like the Thai Medical Council , the Thai Nursing Council , etc. can accredit that the professional morals, the professional standards and the rules are really operated. The hospitals will then be famous and accepted by people and private organizations, such as the insurance companies, the factories, the business firms, as well as the managers of the health funds like the office of Social Welfare, etc. They will be selected as the ones for the personnel of these organizations.

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Consequently, the first 35 sampling hospitals participating in the hospital accreditation program willingly comprise of both governmental and private ones. There are 12 private hospitals, a medical school, a military medical hospital, 7 community hospitals and 14 hospitals under the control of the Ministry of Public Health. Since the project started in 1997, there were 7 hospitals being declared accredited. According to Anuwat Suppachutikul (1998:19), the other hospitals could not improve themselves to achieve the goal of accreditation because the executive committees did not participate actively, the departments could not cooperate well. Moreover, that the doctors did not join in the program much, the officials did not understand in quality, and the problem solution was continued with the traditional method were also the reasons. The research on evaluating eight sampling hospitals under the control of the Ministry of Public Health in the Total Quality Management project by Ongart Wiputhsiri (2000:186) also revealed that each hospital in the program differentiated in terms of the level of quality improvement progress. The causes were the drive of achievement of both senior and junior leaders, the organization's strategic plan and operation, the human resource improvement in terms of quality, and the emphasis on activities directly concern patients' treatment. The three most essential factors leading to the success of the project were essence awareness and participation of all officials, essence awareness and support by the executive committees and training. Chatree Banchuen (1998:32) also stated that attitude changes, personnel's readiness towards quality improvement, building up awareness in urgency and necessity among the personnel from the director to the officials were the first features which must be created in the organization. The hospitals which the leaders understand and support would certainly be more successful than those which the leaders do not understand and support continuously and willingly.

All the information mentioned above indicated that there are several factors influencing hospital quality improvement; however, the most important one is "human" as "human" is the main key which brings the qualitative public services to people. Human is also the resource which can be developed continuously. It is the one which causes changes in quality improvement. Nevertheless, the vital features are

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that attitude changes and personnel readiness in order that the capacity can be fully developed. It is also important to create actives, awareness in urgency and quality improvement necessity among the officials so that they would have good attitudes towards changes and pay a great effort on quality improvement. In addition, they would understand quality improvement in the same way, work cooperatively and participate in the project. These changes can happen when all executive committees, especially the senior and the junior ones, play a vital role in leading and assisting them as well as the changes into the appropriate organizational cultures.

At present, the researcher is a junior executive committee of Nakhonchaisi community hospital. All the three community hospitals in Nakhonchaisi namely Huayplu hospital, Luangporpern hospital and Nakhonchaisi hospital, are improving their qualities to become accreditation, in which qualitative service for people is the ultimate goal, in the first stage which the officials are realizing and learning. However, it is a long distance to the goal, and the improvement is endless because the quality, expected by the community, comprises of several dimensions. It is highly dynamic, relating and changeable by the social, economical and political trends. Quality improvement, consequently, needs cooperation from all officials, from the operators to the executive committees; otherwise, the further improvement can encounter obstacles. The researcher is aware of the essence of this problem, and there have never been any researchers who study on the personnel's readiness in quality improvement and accreditation in community hospitals. The researcher is interested to study on this topic, with an emphasis on personnel's readiness and factors affecting it in quality improvement in community hospitals as well as the problems in quality improvement in community hospitals. This will lead to planning and problem solving in quality improvement for Hospital Accreditation of community hospitals in Nakhonchaisi, Nakhonphatom.

Besides, the results from this study can be applied for the other three community hospitals in Nakhonpathom as the samples in Nakhonchaisi are assumed good ones as this is a study from three out of the eight community hospitals in Nakhonpathom. These three hospitals are located in the developed area by means of

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economics, society and politics. Moreover, there are a lot of big and small factories and villages. However, some people in this area work in the agricultural section, so there is a difference in terms of income. People with a great or average income highly expect a good service from the community hospitals; meanwhile, those with a low income also need the good services as the Constitution of the Kingdom of Thailand appoints. The community hospitals in Nakhonchaisi, consequently, have the duty to develop their service and management properly for the balance between the efficient administration and right and freedom protection for the poor. The hospitals in Nakhonchaisi are improving themselves so that they can achieve the ultimate goal, that is to serve all groups of people qualitatively. It can be assumed, then, that the samples, that are the three community hospitals, can be good ones for the study on readiness of the personnel in quality improvement of the community hospitals in Nakhonpathom, and there will be benefits for other community hospitals in Nakhonpathom.

1.2 Research Questions

1. At what level are the personnel, from the executive committees and officials, ready for quality improvement in community hospitals?

2. What are the factors influencing personnel's readiness for quality improvement in community hospitals? How do they influence? At what level do they influence?

3. What are the problems in the operation of quality improvement in community hospitals? In what aspects should the responsible persons do to build up personnel's readiness?

1.3 Research Objectives

1. To study the level of personnel's readiness, both the executive committees and the officials, for quality improvement in community hospitals.

2. To study the factors influencing personnel's readiness for quality improvement in community hospitals.

3. To study the problems in the operation of quality improvement in community hospitals.

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1.4 Research Boundaries

The researcher has set up the boundaries of this study as follows.

1. It will be a study on the personnel factors, the factors concerning characteristical organizations, and the readiness of the personnel in quality improvement in the three community hospitals in Nakhonchaisi, Nakhonpathom.

2. The population of this study is the government officials who really work in three community hospitals in Nakhonchaisi, Nakhonpathom namely, Huayplu hospital, Luangporpern hospital and Nakhonchaisi hospital.

1.5 Definitions of Terms

Community hospitals mean three governmental hospitals with the capacity of 30 - 60 beds, under the control of the office of the Minister of Public Health, located in Nakhonchaisi, Nakhonpathom namely, Huayplu hospital, Luangporpern hospital and Nakhonchaisi hospital.

Accreditation is defined as the success confirmation about quality improvement from external organizations that the services of the hospitals are qualified as the national standard level. It is a process which is employed as a stimulant to build up quality improvement and self evaluation of hospitals. It is only a tool not the goal as the genuine goal is qualitative services to people.

Quality improvement means the effort to response customers' needs and expectation on the basis of professional standard, with a continuous improvement on operation and proper changes in cultures in the organizations, which builds up better changes. Quality improvement, therefore, is a process which needs well cooperation from personnel, both the executive committees and officials.

Personnel reveal to the governmental officials working in each department of the three community hospitals in Nakhonchaisi, Nakhonpathom namely Huayplu hospital, Luangporpern hospital and Nakhonchaisi hospital. They are classified as the executive committees and the operational officials.

Executive committees are the doctors, the work leaders, the section leaders and the leaders of the patients' dormitories.

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Readiness reveals to the status that happens within a person and urges him to do something with a great effort and active so that the activity will be successful.

Personnel readiness reveals to the status that the personnel understand about quality improvement, the trend and the policy of quality improvement within the organizations in the same way. They will also feel certain that quality improvement will bring about good changes, so they are aware of and believe in quality improvement. This will result in support and participation of all levels of personnel in the organization, so there would be cooperation and teamwork on the basis of the patient center. Moreover, they would struggle for the success in quality improvement and quality accreditation of community hospitals, in which the ultimate goal is good services.

Personnel's readiness for quality improvement in the community hospitals reveal to the readiness of the personnel towards each aspect of quality improvement, such as comprehension, attitudes, awareness, support, participation, cooperation, teamwork, and patient-centered .

Comprehension is the status that the executive committees and the operational officials understand about quality improvement, policy direction in the same way, and they are ready to apply them for their own professional duties.

Attitudes mean the feeling of the personnel towards the urgency and necessity of quality improvement, and that they trust that quality improvement will bring about better changes, so they are ready to try to improve things in the hospitals.

Awareness means the status that the personnel pay attention to the vitality of quality improvement, perceive their roles, try and be ready to make up changes in the service system of the hospitals in order to achieve the ultimate goal, which is good services.

Support is defined as the roles from all levels of executive committees as agent of changes the supporters of the changes and the managers on the administration system for the changes in order to improve the quality of the organizations.

Participation means the status that all levels of personnel of the hospitals join in policy direction plan together with applying the policy practically in order to improve the operation systematically and continuously on the basis on participation of every part of the organizations.

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Cooperation is defined as the professional co-organization between persons or organizations in informational exchanges, intercommunication for problem solving, building up comprehension as well as gathering opinions in order to work together cooperatively.

Teamwork means working behaviors of the groups comprising of personnel in the organization. They must trust in, be responsible and decide to solve the problems together. This will lead to teamwork in every level, the team within the organization, the cross functional team and the professional team. It is a process which provides the groups the opportunity to learn together.

Patient-centered reveals to the work which emphasizes on the needs of the patients in administration and operation (customer focus), emphasizing on the changes in process or working methodology, especially on the features which concern the patients. This includes the consideration on the patients and customers' needs and opinions in order to set up the operational standard and improve the former one so that it can genuinely response the patients and customers' needs and expectations continuously.

Personal factors are the personal characteristics of the samples such as age, educational level, marital status and income.

Operational factors reveal to the working styles of the samples such as position, the type of personnel, the duration in professional operation, the training experience and informational perception on quality improvement.

Factors about opinions towards the characteristics of organizations means the assessment of the opinions of the samples towards the characters of the organizational leaders and the cultural aspects in the organizations. These will reflect the inside features in each organization about the organizational leaders and cultures which support or oppose to personnel's readiness for quality improvement in the community hospitals.

Characteristics of organizational leaders are the characters of the directors of the community hospitals on leadership that supports or opposes to personnel's readiness for quality improvement in the community hospitals. This will be evaluated from the opinions of the personnel in the organizations.

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Leadership reveals to the status that the directors of the community hospitals behave, really try to improve the quality continuously, convey the approaches and goals of quality improvement to every person and initiate it. He must also build up leadership in every level of executive committees and officials, provide everybody a chance to participate in changing and improving as well as encourage and support the personnel to activate and improve the hospitals' quality continuously.

Characteristics of organizational culture reveal to the working behavioral patterns which derive from the approaches, beliefs and attitudes of personnel in the organizations which cause differences in each organization. The characteristics which either support or oppose to personnel's readiness for quality improvement in community hospitals are decision making, problem solving and customer servicing.

Decision making reveals to the status that every level of executive committees distributes the chances to decide to the lower committees and the officials, together with providing them the opportunities to think and try on new things for experimenting new working methods for efficiency. The executive committees, then, would alter their roles from the controllers to become the co- ordinators or coaches.

Problem solving means the status that all levels of personnel can solve the problems systematically with an effort to solve the problems in working process rather than finding out the wrong person in order to build up coordination in improvement and find out solution. The important thing is that every level of officials and executive committees , department and section must be responsible and solve the problems together.

Customer servicing reveals to the status that every level of personnel considers the customers the first priority. They must find out both internal and external customers' needs and response them. All people in the organization are internal customer to one another, and they must service one another in order that it would facilitate in servicing external customers.

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1.6 Research variables

1. Independent variables comprise of,

1.1 Personal factors are as follows:

- age
- educational level
- marital status
- income.

1.2 Operational factors are as follows:

- position
- type of personnel
- duration in professional operation
- training experience
- informational perception about quality improvement.

1.3 Factors about opinions towards the characteristics of organization are as follows:

- characteristics of the organizational leaders
- characteristics of the organizational cultures.

2. Dependent variable which is the personnel's readiness for quality improvement in the community hospitals.

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1.7 Variables and Levels of Measurement

Independent variables

Variables	Level of Measurement
- Age	Interval
- Educational level	Nominal
- Marital status	Nominal
- Income	Interval
- Position	Nominal
- Type of personnel	Nominal
- Duration in professional operation	Nominal
- Training experience	Nominal
- Informational perception on quality improvement	Nominal
- Characteristics of organizational leaders	Interval
- Characteristics of organizational cultures	Interval

Dependent variables

Variables	Level of Measurement
- Personnel's readiness for quality improvement in the community hospitals	Interval

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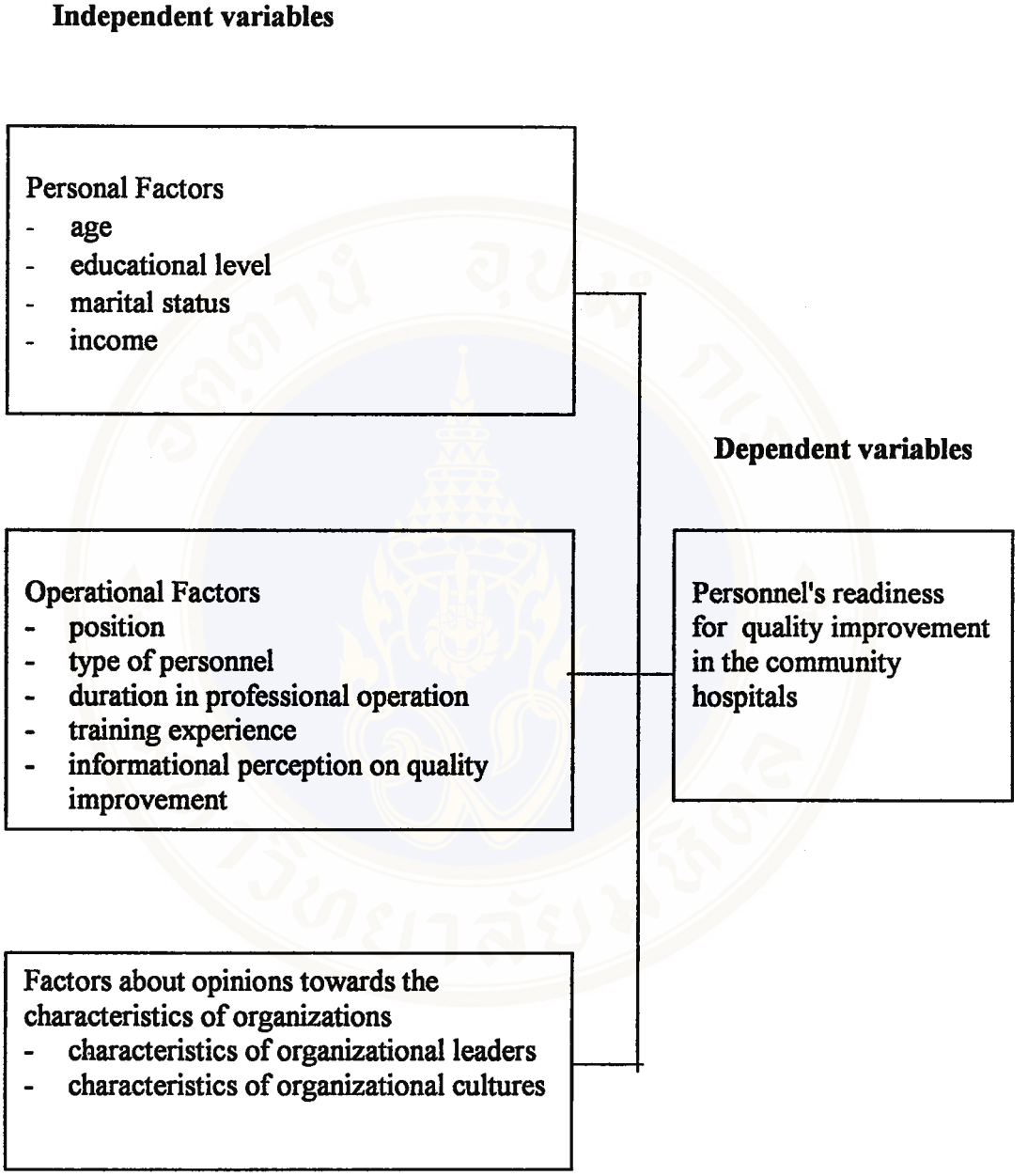
1.8 Research Approaches



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1.9 Research Hypotheses

1. Different personal factors such as age, educational level, marital status and income, cause different level of personnel's readiness for quality improvement in the community hospitals.

2. Different operational factors such as position, type of personnel, duration in professional operation, training experience and informational perception on quality improvement, result in different level of personnel's readiness for quality improvement in the community hospitals.

3. Different factors about opinions towards the characteristical organizations such as the characteristics of the organizational leaders and cultures, result in different level of personnel's readiness for quality improvement in the community hospitals as follows.

3.1 Different characteristics of the organizational leaders in terms of leadership result in different level of personnel's readiness for quality improvement in the community hospitals.

3.2 Different characteristics of the organizational cultures such as decision making, problem solving and customer servicing result in different level of personnel's readiness for quality improvement in the community hospitals.

4. Personal factors, operational factors and factors about opinions towards the characteristics of organizations influence the changes of the personnel's readiness for quality improvement in the community hospitals.

1.10 Expected Advantages

1. New knowledge on personnel's readiness for quality improvement in the community hospitals, findings about factors influencing personnel's readiness and factors about the characteristics of organization which affect personnel's readiness for quality improvement of the community hospitals can be used as the fundamental data in application for preparing personnel's readiness to quality improvement and accreditation of the community hospitals.

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2. The findings will directly be beneficial to the community hospitals in Nakhonchaisi, Nakhonpathom, which are the targeted population, as well as all other community hospitals in Nakhonpathom.

2.1 The level of personnel's readiness for quality improvement in the community hospitals in Nakhonchaisi, Nakhonpathom, both the executive committees and the officials, can be obtained.

2.2 We will know the factors or variables about personnel and the characteristics of organizations which influence the personnel's readiness for quality improvement as well as the problems in quality improvement process. Then, we can solve the mistakes in quality improvement and accreditation of the community hospitals in Nakhonchaisi, Nakhonpathom.

2.3 It will be a good suggestions for the directors of the community hospitals in Nakhonpathom, that can be utilized as the fundamental data for preparing and improving personnel's readiness for quality improvement in all community hospitals in Nakhonpathom.

3. It would be advantageous to the future studies and the further researches on quality improvement and accreditation of the community hospitals under the control of the Ministry of Public Health.

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CHAPTER 2
LITERATURE REVIEW

In this study, the researcher has gathered the approaches, the theories and the related literature in order to be the fundamental approach for the study as well as to complete the study itself. The details of the content are divided as follows.

2.1 The approach on quality

2.1.1 Definitions of quality

2.1.2 Quality approaches about medical services

2.2 Quality improvement

2.2.1 Approaches on quality improvement

2.2.2 Principles on quality improvement

2.2.3 Factors which support or oppose to personnel's readiness for quality improvement in the community hospitals

2.3 Readiness for quality improvement and hospital accreditation

2.3.1 Approaches on quality improvement and hospital accreditation

2.3.2 Approaches and theories about readiness and attitudes

2.3.3 Approaches on preparation to quality improvement and hospital accreditation

2.4 Related literature

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2.1 Approaches on Quality

2.1.1 Definitions of Quality

Feigenbaum (1991:7) defines quality as the decision of the customers, not the officials or the executive committees. Quality in manufacturing cannot be achieved if the products are poorly designed, inefficiently distributed, incorrectly marketed, and improperly supported in the customer's site. Therefore, quality can be assessed by the experiences of the users on those products or services, as well as their needs or expectations.

Crosby (Crosby, in Tenner & DeToro, 1992:21) defines quality as "conformance to requirements, not elegance." It does not reference the manner in which the item is constructed or the method by which a service is provided. In fact, it focuses on trying to understand the full array of expectations that a customer has and drives organizations to meet these expectations.

Meanwhile, Jurun (Jurun, in Cortada, 1995:10) has documented quality that it means fitness for uses of the product or service customers. He emphasizes understanding who the customers are , and what they want.

In the meantime, David Garvin (Garvin, in Tenner & DeToro, 1992:29-30) writes about approaches and revolution of quality in his book titled "Management Quality" as follows.

1. Quality is transcendent. It is evaluated after the production is over. According to this approach, the products will be qualitative after its production is completed. Consequently, the quality improvement cannot be defined.

2. Quality is product-based. It depends mostly on the existence of the qualitative details. If the character is needed, the product can be sold. Therefore, the services or products that are needed are considered more qualitative.

3. Manufacturing-based quality is defined as the appointment on needs and features of the products or services before being produced. If they cannot be manufactured as expected, it means they are not qualitative. The needs and features, additionally, must response the customers' needs so that they would be satisfied.

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4. User-based quality depends on the users' point of view. Quality reveals to the status that the producers can response the customers' needs and expectations. This approach supports Kotler's idea on marketing that the ultimate goal is to response the users' satisfaction absolutely.

5. Value-based quality is defined as the status that the customers accept in the characteristics of the products or services, such as prices.

2.1.2 Quality in Medical Services

At present, there are many terms for quality in medical services. The popular ones are "quality of service" and "quality of care." In this study, "quality of care" is mentioned as it is widely used in the national literature and it is employed in quality improvement and evaluation. Quality, consequently, can be defined as follows.

Quality means the appropriate and standardized characteristics, with zero defects, which bring about good outcomes and response the users' expectations with satisfaction, as indicated in Diagram 1. (Jirut Srirattanaball, 2000:3-5)

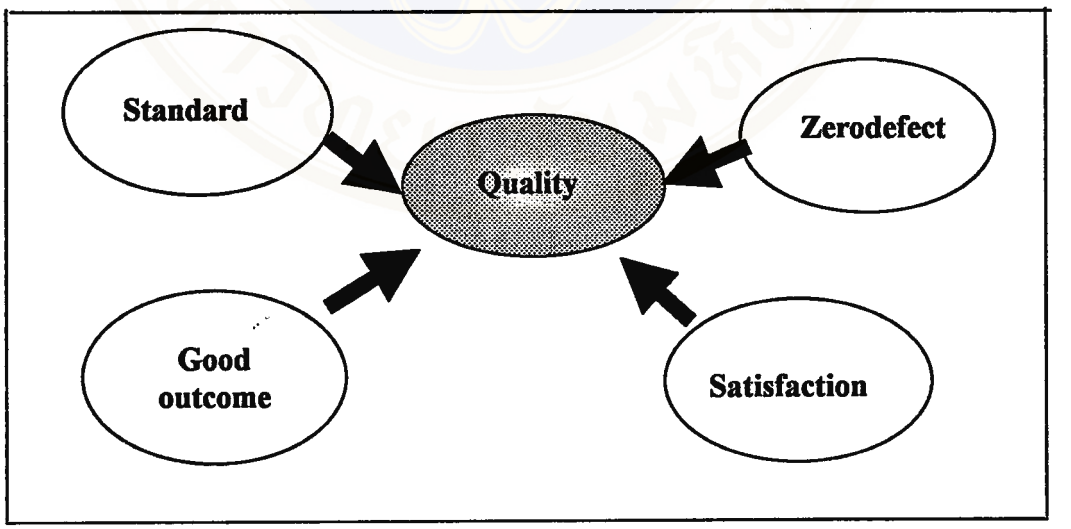

Diagram 1 indicates the boundaries of the quality in medical

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However, the approaches on quality in the health service system is continuously changed and spread, especially in the customers' or consumers' points of view. It can be said that the health services should be improved in terms of methods together with the evaluation and administration so that they would be with "quality" in which the points of view of the stake holders are also included. In 1989, the Joint Commission on Accreditation of Healthcare Organization (JCAHO) has summarized the factors which indicate the quality in patient care. They include 11 points of view on quality from the consumers obviously (Jirut Srirattanaball, 2000: 10-11). Follows are the vital ones. The first is accessibility of care which means the convenience that the patients can undergo the treatment when necessary. Then, timeless of care reveals to the readiness of the care that the patients can receive constantly when needed. Efficacy of care means the proficient administration which can achieve the needs of the service users. Moreover, appropriateness of care suggests that the service must fit the users' needs. Finally, participation of patient and patient family in care reveals to the care that provide a chance for the patient himself or his relatives in decision making on the symptoms and treatment.

In addition, Vinant K. Omachonu, 1990 (cited in Jirut Srirattanaball, 2000:11) states that there are 2 constituents concerning the quality of health care in the hospitals as follows.

1. Quality in terms of operational standard that means the operation in accordance with the standard established professionally.

2. Perceptive quality that means one which response the service users' needs.

The idea coincides with that of Anuwat Suppachutikul (1999:2) who defines quality as the process of responding the customers' needs and expectations, based on professional standard. This definition tends to create balance between quality in the officials' points of view and those in the customers' in order to set up the methods in quality improvement of the hospitals. Anuwat Suppachutikul, besides, has classified quality into two dimensions.

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1. "Must be quality" which reveals to something in the customers' needs. If it is not responded, the customers will not be satisfied.

2. "Attractive quality" which means something beyond the customers' expectations. If it is not responded, the customers feel nothing. However, if the customers receive it, they will feel impressed. Therefore, "must be quality" is the first priority which should be considered, and "attractive quality" should be provided if possible.

From the literature review about the approaches on quality, it can be said that the quality of health service system of the hospitals presently emphasizes on responding the patients and customers' needs and expectation, on the basis of professional standard. This definition is wider than the past approach on quality that focuses only on quality on professional, technical or operational standard, without considering the patients or customer's opinions and expectations. The quality perceived by the patients and customers are the standardized one which is considerably interested in the present time because it fulfills the definition of quality.

2.2 Quality Improvement

There are two main aspects concerning quality improvement as follows.

2.2.1 Approaches on quality improvement

Approaches on quality improvement do not occur recently in fact, they are in the process of gathering several theorists' thinking methods from the ancient time. When the European industrial revolution took place in the eighteenth century, the new method in quality administration rose up. The essential feature of this industrial revolution is the mass production that changes from producing by human into that by machines. The constant standard of products is therefore necessary. At first, the quality administration concerned mostly with quality investigation and control, so the apparent effect is wasting. (Weena Kositsurangkakul, 1999:2; Anuwat Suppachutikul, 2000:17-18) Later, in the nineteenth and twentieth centuries, a lot of famous theorists proposed many approaches on quality improvement.

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W. Edwards Deming is the person who distributes the approach on quality control into Japan, and he has used the process in statistical quality control (SQC) which reveals to theoretical and statistical utilization in every production step in order to manufacture the most advantageous products economically. Its philosophy is that quality problem prevention causes better economical incomes than problem investigation. Deming also proposes 14 points on quality administration (Deming's 14 points) and confirms that his theory on quality control can be used in both the service and industry sections. The brief details of Deming's 14 points are as follows. (Payom Wongsarasri, 1991:253; Witoon Simachokedee, 1999:8-22, Anuwat Suppachutikul, 2000:23-24, 29-33).

1. Create and publish to all employees a statement of the aims and purposes of the company or other organization. The management must demonstrate constantly their commitment to this statement.

2. Learn the new philosophy, top management and everybody.

3. Understand the purpose of inspection, for improvement of processes and reduction of cost.

4. End the practice of awarding business on the basis of price tag alone.

5. Improve constantly and forever the system of production and service.

6. Institute training for skills.

7. Teach and institute leadership.

8. Drive out fear. Create trust. Create a climate for innovation.

9. Optimize toward the aims and purposes of the company the efforts of teams, groups, staff areas, too.

10. Eliminate exhortations for the workforce.

11. (a) Eliminate numerical quotas for production. Instead, learn and institute methods for improvement.

(b) Eliminate M.B.O. (management by objectives). Instead, learn capabilities of processes, and how to improve them.

1. Remove barriers that rob people of pride of workmanship.

2. Encourage education and self-improvement for everyone.

3. Take action to accomplish the transformation.

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Philip B. Crosby, in 1979, published a book named "Quality if Free" which improved the approach on Zero Defect as the qualitative goal, and emphasized on creating zero defect culture. He, therefore, put an emphasis on preventing mistakes in cost of quality which is defined as the cost derived from bad quality. He believed that the defects are caused by two reasons: lack of knowledge and lack of interest. Then, he proposes fourteen methods in quality improvement (Crosby, in Tenner & DeToro, 1992:22; Richard and Knod, 1991:147; Witoon Simachokedee, 1998:25). The vital ones are management commitment, quality improvement team, quality awareness, employee education, etc.

Total Quality Management (TQM) approach and principle

It can be said that the Total Quality Management (TQM) derives from the ideas of two American people, namely, W. Edwards Deming and Joseph M. Juran, who are experts in quality administration and statistical process control. Their ideas are spread into Japan as a combination between the principles in quality control as well as problem solving process and principles on participation of the operators. Q.C. Circle, a method of building quality group, is originated as the initial stage of combining the technical principles and principles on organizational behaviors together. Then, it has been continuously developed and become TQC (Total Quality Control) or finally TQM (Nursing Section, 1994:1-2).

Many theorists have defined TQM. Follows are just the examples.

Mondy and Noe (1993:331) describe that total quality management is the advanced managerial philosophy which focuses on continuous improvement process in order to create good products or services. The final goal of the total quality management is the customers' satisfaction.

Bernadine and Russell (1993:538) state that total quality management is an experiment that needs participation from every level of officials and executive committees. It is a process to change the organizational cultures together with the goal, thinking method, philosophy and operational method. The focus of total quality management is that every level of officials and executive committees are responsible of improving products or services' quality continuously, so that the customers would be satisfied.

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Anuwat Suppachutikul et. al. (2000:27, 58) defines total quality management as a systematic strategy to build up participation of the entire organization in planning and improving continuously in order to response the customers' needs and expectations.

Among health organizations, there exists another word, CQI, together with TQM, and sometimes these words are interchangeable. CQI (continuous Quality improvement) means the effort to response the customers' needs by improving the operational methodology continuously and systematically. Moreover, it must be an effort to better up the quality, without any satisfaction with the present quality. The continuous process improvement for responding the customers' desires needs cooperation from both officials and executive committees in the whole organization.

2.2.2 Principles in Quality Improvement

For quality improvement of the hospitals, the institute of public health research has employed the principles of total quality management and continuous quality improvement as the improving method with the public hospitals under the control of the ministry of Public Health since 1995. Its main objective is to apply the new approach on quality improvement with the health service system. Moreover, it has portrayed the principles or essence of total quality management and continuous quality improvement as customer focus, common vision, employee involvement and empowerment, process focus, scientific process and problem solving process, leadership, and continuous improvement (Anuwat Suppachutikul, 1998:46-50).

1. Customer focus

Customers are the ones who appoint the necessity of our organization. If there is nobody who gains advantages from our operation, there is no need to have our organization. Our duties to our customers are to study their needs, response them and accept the reflections of our services.

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2. Common vision

The first important thing in quality improvement is that the organization must receive the faith from the officials. Having common goal and vision is to receive the faith. We have to provide them the opportunities to set up the goal and vision, then the goals and visions are exchanged in order to find out some common ones. Essence of building up vision does not lie upon the statements but on the process that everybody has involved and feels owning, so that the activities can be created. This is considered cooperation for creation, and members can join in appointing the goals and changing behaviors to the goals together.

3. Employee Involvement/ Empowerment

The most essential resource is human which can be continuously improved more valuably. Human causes changes from behavior, attitude and social value improvement in order to enhance their own capacities. Each person cannot work and succeed in his work by himself only. He needs cooperation and teamwork which derive from practicing necessary skills, understanding team members' thinking methods, using group process to create the learning chance, building up new organizational cultures, and transferring the power for teamwork. The officials should receive more power via informational training as well as building up a new system which comfort teamwork's operation.

4. Process Focus

Process is the continuous working step which brings about more valuable outcome as we expect. Health service operation comprises of several interactive processes, so the problems always take up during the joints of these processes. Focusing on process improvement instead of focusing on accusation or finding out the one who does wrong results in cooperation in improvement. As most problems are caused up by the inefficient working system, quality improvement is the process improvement to become more efficient and easier for operation. It is a method which makes the officials work with their full capacities.

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5. Scientific Process/ Problem Solving Process

This is a process of employing the scientific method or problem solving process to solve the problems. We should learn by analyzing data, finding reasons and observing actions. Practically, we may ask some easy questions in order to undergo this process. For example, What is the problem? Why should I do this? Is it good or bad, and how can it be evaluated? How can I improve this process?

6. Leadership

The leader is the one who plays the most important part in employing total quality management or continuous quality improvement into operation. He is also the one who assigns whether it would be successful; therefore, what he should do are to study the process comprehensively, originate it, support the officials, and evaluate the managerial system to comfort the continuous improvement. The leader is vital in causing changes, so he should alter his role from the controller and commander into the coach.

7. Continuous Improvement

As technology and customers' needs change, it is necessary to improve the service continuously. This principle comforts us to look for the improvemental opportunity continuously, and to think that we can do it better in the future. This results in the excellence of the organization.

Kris Utairat (1998:11-13) mentions that the total quality management appoints every official of every position in every department to participate and join in the team, according to the quality policy. The participation, either top-down or bottom-up, emphasizes on finding the improvemental methods continuously, with the belief that "everything can be better than yesterday, and things will get better tomorrow." In this principle, the qualitative service is the ultimate goal of which quality comprises:

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Q (quality) reveals to the quality of products, services and officials.

C (cost) reveals to the cost in production or service that must be controlled proficiently so as to reduce the waste, unnecessary cost, duplicate work and to improve operation constantly.

D (delivery) reveals to the delivery of products or services to the customers as rapidly as appointed.

S (safety) means the safety of the customers as well as that of the officials, including the equipment and tools. They must be without any risks or accident (zero defect).

M (morale) means that every official must have good morale in order that they would trust the commander and believe in the organization so that they would devote themselves to work qualitatively.

E (environment) reveals that the environmental administration must be good in order to manufacture the products or services that do not harm the environment.

E (education) means that knowledge and comprehension in skills must be offered in order to develop the quality.

I (image) means that the image to public or customers must be good. Building up image must lie on the reality and correctness, not lying them.

Witoon Simachokedee (1998:38-54) states that the principles of organizational quality improvement with total quality management are mainly aimed to be quality-oriented management with continuous quality improvement in order to satisfy the customers. Moreover, every official in the organization must participate (total involvement) in the management. It is a managerial system which collects the efforts from all people concerning with producing the products and services in order to develop the quality in every producing step. Every official in the producing process, consequently, influences the quality of products or services conveyed to the external customers. It can be said that the operational officials know the problems and can solve them the best as well as build up the shared values for quality cultures as follows: customer focus, customers' satisfaction, importance of internal customers, teamwork,

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long-termed improvement, solving problem orientation, participation, process-oriented work and continuous and real effort.

In accordance with the above principle, Anuwat Suppachutikul (2000:2-8) states that quality improvement is both operational culture changes and operational system improvement. These changes can take place in case every level of executive committee is the leader who supports and manages the administrational system to comfort the changes. Obvious role discrimination between the leader and the officials results in appropriate changes. That is, the leader plans on the changes' trend and aspects; meanwhile, the officials plan on the changes' methods or details.

Initiating quality improvement is the process in originating or finding out the opportunities to develop the quality. It comprises of several levels, namely, top-down, junior executive committee, official himself.

1. Top-down initiation is the process in planning the long-termed objectives of the organization and transferring these objectives into the strategic plan.

2. Junior executive committee initiation starts from the process that the leader of each department plays a role in leading his fellows into standard establishment and operational method improvement within each department.

3. Official himself initiation is the process that the official has a role in searching for the opportunities for developing and conducting the improvement process himself, under the policy boundaries and with the support from every level of executive committee.

Thida Ningsanont, additionally, says that although operational system improvement is a vital principle in quality improvement of the hospitals, the developed operational system can exist only if the officials in the organization help keep it. The officials themselves, moreover, must be improved together with the system. They must know expectations and what the goal of the organization is. They must learn together, help one another, think and work as a team in order to bring the organization to the established target. Essentially, quality improvement will exist only if the officials in the organization change their approaches or visions (paradigm shift) as well as think differently and creatively, accept others' suggestions and opinions. The traditionally operational cultures that must be shifted are as follows.

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Traditionally Operational Cultures	Newly Operational Cultures
- finding the ones who do something wrong for punishment	- When there is a mistake, the operational system should be investigated in terms of limitation. Then, the officials should think together to solve the problem in order to prevent the mistakes.
- being satisfied in the present condition and improving only the problematic features	- Improving the system continuously although there is no mistake.
- working only in one's field	- working as a team between departments
- solving current problems	- solving problems systematically in order to prevent problem duplication
- feeling that the present condition is good and there is no need to change as it may cause trouble	- There should be an indicator to reflect the working outcome and to compare it to the standard or expectations. The changes may be observed when time passes by.
- wanting to try nothing new because of fearing of the mistakes	- Each creative idea should be employed for improvement. There may be many more methods that would make operation more proficient.

Despite of changing the traditional thinking method or traditionally operational cultures in terms of work and system, every level of executive committees must change their thinking methods about employee empowerment in order to build up teamwork as follows.

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Traditional Thinking Method	New Thinking Method/ Employee Empowerment
- The leader is someone who knows the best. He must be the one who decides, commands and controls the officials.	- The officials know the problems the best. They should have a chance to decide and solve the problems themselves. The leader should support and facilitate them to solve the problems. Moreover, the leader is the one who improves the work that is beyond the officials' boundaries.
- The officials cannot be cleverer than the leader.	- The leader should empower the officials. He should understand their needs and problems and make them powered. They would want to use their knowledge and skills in problem solving and improvement. The leader, furthermore, should wipe out fear and provide them a chance to try out the new ideas without fear in case any mistakes happen.
- The best leader is the one who follows the situation.	- A good leader is someone who can convince the officials to share the vision and try to achieve that goal.

Source: Hospital Accreditation Institute . Thinking Method Improvement. 1999:3

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Worrapat Poocharoen (2000:24-30) states that a good leader must convince all officials in the organization to share the vision and try to operate in accordance with that approach. This can happen only if the officials participate in the organizational administration and there is a practice which trains the officials to work and manage themselves. The executive committees only assign the criteria, and the officials think on the proper operational methods in order that they would elicit their best aspects for the organization. Crucially, the modern executive committees must be as teachers, not the bosses. They should learn more, have techniques in conveying ideas and act as a consultant.

Taweesak Hoonnak (2000:52-53) describes about the leadership and product increase that a vital factor which results in continuous quality improvement is leadership of the executive committees, both senior and junior ones. Leadership takes an important role in building up good environment and relationship in order to motivate the officials to develop the quality and increase the products throughout the organization. The organizational leaders can create cultures in operational improvement continuously by applying the change process, both top-down and bottom-up, so-called participation management and decentralization management, into the administration of the organization.

Besides, the organizational leaders should show up the roles necessary to quality improvement in order to increase the products continuously. The roles of the leaders are rather different to those of the executive committees as the leaders appoint the vision and develop the strategies as well as manage the organization, build up team and manage the team dynamics in order that all members can fully show up their roles and capacities. The leaders must also be a good communicator, so that the officials can understand absolutely. They must be good models who have a long vision and ambition in order that the organizational cultures would be shifted via the process of changing all levels of officials' behaviors. However, the administration would focus on functioning as the traditional system by the managerial circuit such as POSDCORB, etc. This doesn't mean that leadership cannot be more crucial than management or vice

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versa. However, both must get along because the organization would be regressed and cannot be continuously developed if it emphasizes only on management (Jintana Yunipan, 1996:102; Taweesak Hoonnak, 2000:52-53, Bhradhammapidhok, 1999:63-72).

2.2.3 Factors supporting or opposing personnel's readiness for quality improvement

From the literature mentioned above, the researcher can summarize that the characteristics of organizational leaders and organizational cultures relate to quality improvement, and they support or obstruct to personnel's readiness for quality improvement. Therefore, the deep consideration on organizational behaviors that refer to organizational leaders and organizational cultures should be conducted as follows.

1. Organizational leaders

Organizational leaders in this study mean the directors of the hospitals, who are senior executive committees. They are the key factors to the success. As executive committees, they function in management: planning, organizational management, commandment and control. In the meantime, they have a vital role in leadership. How well they can lead the personnel or members in the organization to the quality improvement of the hospitals depends on their leadership.

Regarding leadership, many academies have defined it into several definitions as follows.

Stogdill (1974, cited in Somyot Navykarn, 1995:400) defines leadership as the process in influencing the organizational groups in order to achieve the set goal.

Milton (1981:292) thinks that leadership is a status that the leaders use their power under the relationship with their follows in various situations in order that each person or group tries to activate to achieve the targeted goal.

Ross and Hendry (1958:102-103) studies and compares the leaders' characteristics and proposes an approach about leaders that the leaders' characteristics depend on the group. Groups and leaders cannot be separated from each other. If

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there is not a group, there is not a leader. If the group lacks a leader, it is hard for the group to develop. Leadership is a process that the leaders must act both in leading and managing.

Danai Tienput (2000:193-196) mentioned that all leaders are the managers, but the managers are not all the leaders. The characteristics of the managers with leadership is the ones who have the knowledge and ability in coincidence with the organization, have the visions, be able to predict the problems continuously and systematically and try to prevent these problems. Moreover, they pay a great attention on operation, reject accepting familiarity by feeling want to change the working process. They are eager to gain the operational methodology from the successful people or organizations. They dare to decide or take risk when they have to choose for the possible choice in order to achieve the goal. The organizational leaders must always create new things to solve the problems or to develop the products or services. They must think in the different ways from the opponents. What they do, show off is their images which their fellows would imitate and do as well.

Regarding the theories concerning leadership, it is found that there is an interesting and crucial theory which is called "Personal Behavior Theory." This is the theory which are widely studied by a lot of people. The researchers of Michigan State University find that the most efficient leader is the one who has a good relationship with his fellows by supporting them to decide in group instead of do it personally. Moreover, he supports his fellows to assign and succeed with the operational target on 3 assumptions. The first one is the organizational leader is the one who has duties on changes by group power. Then, the influences of the organizational leader are advantageous to the good changing process. Ultimately, the organizational leader is the most appropriate person to lead the organization into changes (Somyot Navykarn, 1995:408-410; Arun Raktham, 1989: 36-37).

From the reviewed literature on organizational leaders, it can be summed that the leaders are the ones who take an important role and leads or co-ordinate the organizational members' operation to the success. They must be accepted by organizational members. They must have leadership which means the process of power

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utilization of the leaders, both in leading and managing members in activities, so that each member or group has an effort to activate or function to achieve a goal in various situations.

In quality improvement, therefore, which is a continuous process to alter the organizational cultures and the operational system, there needs an initiation from the organizational leaders. The good leaders would have a clear vision about in what way the organization would develop to. Moreover, they must convince or motivate all officials in the organization to co-operate in the improvement to that goal. Efficient leaders must improve all levels of executive committees to understand the roles and the organization's goal (JCAHO in Consider this, 1994, cited in Tabthip Thitipongpanit, 1996:38). The main roles of the organizational leaders and executive committees mentioned above coincide with the ideas of Besterfield and others (Besterfield et. al., 1995:15-16). They state that the main roles of the organizational leaders are to make a lively vision, help officials work effectively, and stimulate to build up leadership in every level of executive committees. The leaders must comprehend human basic needs that human needs freedom and safety at the same time. They are sensitive to awarding and punishment. They want to hear something that they are proud of. They believe more in actions than in statistical information. They do not trust the leaders who say something but do the opposite. Several academies, therefore, summarize that the leaders must give freedom to the officials and manage the safe environment as well as awarding when the officials succeed. Moreover, they must provide them an opportunity to create and motivate them positively since the officials always believe that work is more important if they are a part of it. Essentially, about changing the thinking methods of the organizational leaders for quality improvement, the executive committees must understand that eighty five percent of variation is common. That means it needs management from the committees. Another fifteen percent is special, and the officials can solve it themselves. The leaders must also share the power and influence to the others, which is called empowerment. They must empower the executive committees. A good leader must turn down the triangle of power to be upside down, in which the leader is at the bottom. The leaders must enhance the executive committees' capacities and leadership. They must support, stimulate and

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facilitate the committees so that the committees can evaluate and improve their operation (Kai E. Roland, 1993, cited in Anuwat Suppachutikul, 2000:63-90, Anthony Wagemakers, 1998:65).

2. Organizational cultures

Culture derives from learning the society which a person is a member. It is something that members in the same society have or conduct together as a principle in living in the society. Culture varies in each society. One in a society differs from that in another. It results in different ways of lives as well as features such as in society, politics, governments, administration, etc. However, it can be changed. Human can create and improve to form a new culture to fit the new and changed situation such as in freedom, political ideas, administration or others. In sum, culture is the way of life or all behaviors derived from learning and transferring from a generation to another either directly or indirectly. It bends people in the society together. It, consequently, influences people's ideas and behaviors. It can also be said that decision making behaviors or the behaviors of people in the organization are caused by organizational cultures (Paiboon Changrien, 1989:12-13, 75-76; Paisan Kraisit, 1992:17).

Several academies define "culture" differently as follows.

Krit Suebson (1992:4) describes that organizational cultures are the patterns of thoughts, beliefs, social values and social norms that most people in the organization behave and transfer. Organizational cultures are the ways of lives in the organization, and every organization has its own cultures. All levels of executive committees have a role in building up or making up cultures in order to use them as a tool to achieve the organizational goals.

Tylor (1871, cited in Paisan Kraisit, 1992:15) is the first theorist who uses the word "culture." He defines cultures as the complex aspects which include knowledge, beliefs, moral, laws, tradition, ability, and behaviors of a person as a member of the social group.

Backer (1987, cited in Sujin Sawangsri, 1999:28) states that organizational cultures mean the comprehensive system of members in the organization which results in various cultures in different organizations.

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In conclusion, organizational cultures mean the patterns of operational behaviors which can be obtained from thinking methods, beliefs and social values of people in the organization, that make cultures in each organization different.

The importance of organizational cultures can be analyzed as follows (Paisan Kraisit, 1992:20-22).

1. Not only do organizational cultures influence each person's behaviors to other people, but they also help predict how a person would behave towards us. Each organizational culture is the expectancies.

2. Organizational cultures appoint one's behaviors; hence, they help describe the behaviors of people in the organization.

3. Cultures are the sources of problem solving methods. These problems are always encountered and solved in the society. Different cultures also result in different solving methods.

4. Cultures influence and reflect world views of people in that society. Besides, they are more powerful than motivation and one's opinions. They make people think differently.

Paiboon Changrien (1989:81-90) describes the forces of organizational cultures upon the behaviors of members in the organization. The crucial aspects which can be considered are as follows.

1. Behaviors of the relationship between the commanders and the officers, especially in the governmental organizations, are influenced by the vertical relationship culture, from top to bottom rather from bottom to top. This results in personalization of power instead of the power in accordance with the structure or the duties in administration. Moreover, the officers dare not state their opinions which are opposite to those of the commanders, so there are no new creative ideas, but inefficiency instead.

2. There are influences of cultures upon the behaviors in relationship between people in the organization and other people. They are considered an interaction between the organization and the society, especially for the governmental

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organizations. The cultural influences in this case somewhat lie upon personalization rather than the organizational goal.

It can be concluded that organizational cultures have two essential aspects that are organizational cultures about thoughts and behaviors. This means, thoughts, beliefs, social values and comprehension of organizational members cause decision making behaviors, the decision making process or decision making on operational method of people in the organization which may be called "operational cultures."

Quality improvement is the change and effort to change the organizational cultures in terms of thinking methods, beliefs and social values which once are accepted and conducted, such as powerism, acceptance in the traditional position, being fond of being a follower, and individualism. This case is especially in the governmental organizations which the structure is like a pyramid, in which the centralization takes place. All decisions in these organizations are top-down, and the communications is one-way. Rules and regulations are for controlling, and ignorance on being human happens. These organizations need changes to new beliefs and social values about democracy, acceptance in other people, participation in decision making and realizing the values of changes, with an emphasis on decentralization, empowerment, participation in decision making and motivation. These features would cause better operational behaviors of officials, and the organizations can approach their goals more easily. These changes are on thinking methods, beliefs, social values and social norms that most people have conducted and transferred continuously. In other words, it is a change in organizational cultures (Krit Suebson, 1992:31; Chiowchan Arsuwattanakul, 1989:200-201; Anuwat Suppachutikul, 1999:P06).

Changing organizational cultures is cultural changing that differentiates learning about the targeted goal, obligation, beliefs and social values of people in the organization. Changing must be originated from the leaders to the officials, melting to form a new organizational culture in order to approach the excellence because organizational cultures have many effects upon the organization. They affect everything in the organization. A strong and unique culture makes everyone know the goal of the organization and devote himself to achieve it. In contrast, if the culture is not strong, the personnel will waste their time on searching for how or what to do.

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This indicates that organizational cultures really influence the organization's success, and they are the essence that makes everyone believe in the organization and devote himself to work for it (Graham, 1995:40-45; Krit Suebson, 1989:12-13). Anuwat Suppachutikul (1999:12B01) also states that the governmentally organizational cultures that obstruct cooperation amongst personnel in quality improvement of the community hospitals are as follows.

1. Personnel are under the thinking method of control and investigation. This creates fear and fixation to traditional opinion. Innovation can never happen as the officials dare not state their opinions.

2. There are no learning or continuous improvement cultures. Emphasis on outcomes rather the co-operational process results in conflicts within the team instead of learning how to work together amongst people with different opinions. Additionally, there is not analysis on the mistakes or failures so as to find out the weak points and search for the new operational methodology.

3. The system responses the officials' needs rather than the customers. This system is set up for the officials' convenience, so it causes trouble and inconvenience for the patients who become secondary instead of the most important.

4. People always think that most problems are caused by an individual rather than the system. When a problem rises up, a question on who did it is always asked, and it causes no cooperation in problem solving. Moreover, they do not try to solve the problematic system, but to look for the wrong person. The officials are the victims of the operational system without investigation, as a result.

5. It lacks of co-ordination and co-operation between the departments. Problems caused by transferring the work between the departments or professional co-operation cannot be solved, consequently.

6. The executive committees do not play any roles in support or encouragement. Therefore, there is no co-operation for changes. The executive committees themselves, moreover, may be the obstacles for the changes.

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7. There is no long-termed goal of the organization. Organizational members do not know how valuable to the society the organization is, so there is no policy direction and cooperation for changes. They are the organizational leaders' roles in conveying the approaches on quality improvement and policy direction of the organization to all the officials and committees in order to bring their efforts into the same direction.

From the above mentioned literature, it can be concluded that the characteristics of the organizational cultures which affect personnel's readiness in quality improvement of the hospitals concern mostly with decentralization in decision making, participation, empowerment to the officials, servicing both internal and external customers, and solving problems on the system rather than an individual. Organizational cultures in this study, therefore, reveal to the patterns of professional behaviors which are derived from thinking methods, beliefs and social values of people in the organization. These cultures differentiating each organization and supporting or obstructing to personnel's readiness for quality improvement in the community hospitals are the patterns of decision making, problem solving and servicing the customers.

Considering the literature review about approaches on quality improvement, principles in quality improvement and factors that support or obstruct to personnel's readiness for quality improvement, it is known that quality improvement lies a great attention on improving the entire operation of the organization continuously in every process. Quality which means responsing the customers' needs for satisfaction is the goal (Witoon Simachokedee, 1998:52; Mondy and Noe, 1993:331). In quality improvement operation, there needs participation from every level of workers, both the officials and executive committees, as it is the changes in approaches, thinking methods, organizational cultures, goal, operational philosophy and operational process (Bernadine and Russell, 1993:538, Thida Ningsanont, 1999:2-3; Anuwat Suppachutikul, 2000:29). Changing organizational cultures or ways of lives in working for quality improvement can take place only if every level of executive committee is the

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agent of change, supporter of the change and administration to facilitate the change. They must provide an opportunity for every official in every department in the organization to share vision and set up the goal together. Moreover, the officials need empowerment to gain more knowledge and power for decision making, problem solving and improving work for participation, co-ordination and teamwork. In the meantime, leadership must be built up in every level of executive committees in the organization by changing from administration to leading, or from a controller to a coordinator. Officials must be offered a chance to learn and decide to solve the problem and improve the operational system without fear of failure or punishment. This will result in leading everybody in co-operating for changes in the service system of the hospital.

It can be concluded that continuous quality improvement that needs readiness from personnel in every department of the organization can be occurred within the conditions of new organizational cultures only if there is a thinking method on decentralization. The decision making must be decentralized to the low level of workers instead of control and investigation. Officials must have a chance to state their opinions, decide how to solve the problem or how to improve the operational process and search for the new working methods in order to response the customers and patients' needs. Empowerment to the officials and operators must be provided via training and providing knowledge and information as well as giving them a chance to think and apply their thoughts in working for proficiency. Importance must be put on improving work instead of looking for the wrong person in order to build up cooperation in improvement and find out the solutions. Moreover, internal customers must be always vital as all officials are internal customers for one another. They must service, co-operate and help one another so that comfort and working agility for external customers can happen. Their service, finally, would really be satisfying for the patients.

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2.3 Readiness for hospital accreditation

2.3.1 Approaches in Hospital Accreditation

Definition of Hospital Accreditation (HA)

Literally, accreditation means to trust on or to believe in something. Therefore, hospital accreditation can literally be defined as quality guarantee of the hospitals. However, in this study, this word would emphasize on the improving process rather than accreditation. Therefore, another word, quality improvement and accreditation for the hospitals, is also employed here. Hospital accreditation is a tool that stimulates improving the organization systematically, and the success would be confirmed by external organizations.

- Hospital accreditation is a confirmation on the success of improvement. It is an accreditation in quality system by the third organization. (The first organization is the one which submits. It can be a manufacturer or servicer. The second organization is the customer.)

- Hospital accreditation is the main trend in quality improvement of health services. It is the national standard in health services.

- Hospital accreditation is the tool, not the goal as the real goal is the good services.

- Hospital accreditation is the tool that stimulates improvement in the internal system of the hospital systematically throughout the entire organization. It makes the organization learn, evaluate and develop itself continuously. Accreditation is only a small part in the last step of the whole process, and it is not the improvemental goal. The real goal is about the services provided to the patients (Anuwat Suppachutikul, 1999:33B01; Methods to Quality and Hospital Accreditation , 1998:18).

People who gain advantages from hospital accreditation are as follows:

Society: believe that the hospital has a credible operational system.

People: know that which hospital they can trust in.

Patients: receive qualitative services, not risky to non-standard treatment or being ignored.

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Professional operators: work under the lowest risks, work smoothly and conveniently.

Hospital: is famous and acceptable.

Committees of the fund for health: have enough data to select the hospital for the patients under their responsibility.

Professional organization: can guarantee that professional standard and rules and regulations are really functioned.

In conclusion, hospital accreditation means a confirmation on the success of quality improvement from the external organizations that the hospital is as qualitative as the national standard. It is a process, utilized to stimulate the quality evaluation and improvement by the hospital itself, in coincidence with a confirmation on that success from the external organizations. Hospital accreditation is only a tool, not the goal as the real goal is to provide good services.

Principles of Hospital Accreditation

The principles of hospital accreditation are really worth studying because there are some parts that are contrast to the traditional opinions, but they are the solutions for improvement. Hospital accreditation is not an investigation but learning in order to build up the learning organization endlessly. It is a learning process by self evaluating and exchanging experiences with the others in order to appoint the professional standard and enhance the established standard continuously as well as manage an easier operational system. Emphasis lies on quality process in which the quality assurance (QA) and continuous quality improvement (CQI) are important in order to approach the needs and expectations of the customers and patients which are dynamic. Accreditation from the external organizations is only a small extended part of quality improvement. In other words, hospital accreditation is a process stimulating quality assurance and continuous quality improvement in order to build up qualitative services. The fundamental beliefs are that quality is caused up by personal efforts, working as a team, patient-centered, standardized operational system and process, together with self-evaluating and improving the system continuously by everyone's

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effort (Thida Ningsanont, 1999:4; Hospital Accreditation Institute, 2000:4; Anuwat Suppachutikul, 1999:38B01).

The above literature apparently reflects that in order to approach the goal in hospital accreditation, personnel must be ready in commitment and work together as a team with the patient-centered basis for all activities. Furthermore, they must manage the operational systems to be standardized and improved continuously in order to response the needs and expectations of the customers and patients.

2.3.2 Approaches and Theories about Readiness and Attitudes

Readiness

Several definitions are defined for readiness as follows.

Skinner (1965:305) has stated that readiness is the base and trend of a person to make his work a success or failure. It depends on whether he is ready or not. A person who is ready will work smoothly and succeed impressively. Meanwhile, a person who is not ready works as if he were forced, so his work cannot be successful.

Good (1973:472) mentions that readiness means the abilities to agree, the desire and the abilities to participate in the activities. These are caused by maturity, experience and emotion of the learners to develop their abilities in learning or activating.

Arthorn Yaopranee (1977:49) defines readiness as the condition or status which happens within a person and makes him do something with a successful trend.

In sum, readiness reveals to the status or condition which happens in a person and forces him to do something attentively, enthusiastically and desirably in order to succeed.

Regarding education, children's readiness is emphasized and it is defined as the growing status together with interests and knowledge which are high enough to help children learn conveniently. Therefore, in instructional management for children, the teachers must investigate their readiness before instruction. If the children are not ready to study in any subjects, it is the teacher's duty to build up readiness in the

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children. Children's readiness concerns with the following factors (Sucha Janaim, 1982:143-147).

1. Internal factors

1.1 Maturity is the highest growth level of children in a period. This growth doesn't mean to only physical growth, but also intellectual, emotional and social ones.

1.2 Previous experience or schema is also important. Children can learn about something effectively if they have background knowledge on that topic.

2. School factors

2.1 The teacher's instructional management must connect with the previous lessons and be in children's interests.

2.2 The teacher's personality is also essential to children's learning as they may love or hate some subjects because of the teacher's personality, such as figures, characters, social characters, being a good sample, being credible, being without bias, being democratic, etc.

Attitude

Many theorist have defined "attitude" as follows.

Ernest (Ernest, et. al. 1971:523) has defined "attitude" as the readiness condition to response the goal, approach or situation.

Sucha Janaim (1982:90) states that attitude is the mental readiness condition that cannot be seen. However, it forces an individual to act as he agrees or disagrees with something.

Preeyaporn Wonganutrarot (1992:64) mentions that attitude is sometimes called opinion. It is defined, according to Allport (1960), as the mental readiness condition which is caused up by experience. It makes a person to act towards another individual, something or concerning situation.

Prapapen Suwan (1983:1) defines that attitude is the mental readiness condition, and it is a state of readiness of a person to a stimulant either in a supporting or opposing way.

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Besides, the essential characteristics of attitudes are as follows (Preeyaporn Wonganutrarot, 1992:67-68; Sathit Wongsawan, 1982:183-192).

1. Attitude comes from experience, learning and stimulants around a person. Environment and culture influence attitude; therefore, people with different gender, age, education, occupation, religion, environment, status and experience would have different attitudes. Specially, people with different cultures would have obviously different attitudes.

2. Attitude is the readiness to response the stimulant. It is a preparation within one's mind rather than outside. State of readiness of a person is the one which assigns behaviors both internal and external ones.

In conclusion, from the study on approaches and theories about readiness and attitudes, although there is no evidence what they directly concern, it can be basically concluded that state of readiness of a person comprises of knowledge, comprehension and attitudes towards that thing or situation. It leads to the supporting behaviors or participation in order to make the activity successful. A person's readiness have two concerning factors as follows.

1. Personal factors such as age, gender, experience about that matter, educational level, training, status, income, etc. cause different attitudes amongst people with different personal factors.

2. Infrastructure factors are the ones about the characteristics within the organization that possibly affect readiness of people in the organization such as the characteristics of organizational leader, characteristics of organizational cultures. Different characteristics of organizational cultures cause different attitudes, for instance.

From the basic analysis and the literature review about hospital accreditation, the researcher can conclude that personnel's readiness for quality improvement in the hospitals comprises of comprehension and good attitudes towards quality improvement together with awareness and attention, support and participation in quality improvement. These will lead to good co-operation and teamwork with the patient-

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centered basis. The factors concerning personnel's readiness in quality improvement are personnel factors, composing of personal and operational ones, and attitudes about the characteristical organizations, composing of the characteristics of organizational leader and cultures.

2.3.3 Approaches in Readiness Preparation for Hospital Accreditation

From the approaches about hospital accreditation mentioned above, readiness preparation for quality improvement of the hospitals has some crucial aspects as follows (Chartree Banchuen, 1998:32-36; Thida Ningsanont, 1999:9-10).

1. In changing attitudes and personnel's readiness for improvement, how can we make all people in the hospitals, from the executive committees to the officials, feel the urgency and necessity for improvement? This starts from the senior executive committees who must decide to develop the hospitals, appoints the responsible persons on quality improvement, create understanding with people in the whole organization, build up efforts and plan the goal together between the executive committees and the officials.

From the previous experience of the hospitals in the TQM project, it is found that the hospitals with the leaders who understand, support and intend in quality improvements are highly more successful than those with the leaders who do not support or intend. At the first stage of the TQM process, it will not be quite successful until a half of personnel in the organization intend. It takes more than two or three years for each hospital, depending on the attitudes of personnel in the hospitals.

Basic methods in changing attitudes of the personnel are as follows.

- Organize a training on organization development (OD).

- Organize a training on excellent services behavior (ESB) with the ultimate goal that the personnel would love, co-operate and be ready to service the customers. Moreover, the team would be able to change and there is a strong co-ordination that understands the quality improvement in the same way.

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2. In developing the visions, obligation and building up a new strategy, the hospitals need to have a clear and possible vision and obligation which is built up from co-operation from the personnel in the hospitals. The personnel would try to function as assigned in the vision and obligation. Moreover, there needs a communicative method to convey the new strategy and vision to the personnel continuously.

3. After preparing the personnel's readiness in terms of attitudes and teamwork, as well as assigning the vision and obligation of the hospitals, there needs a constant improvement on the process for developing quality operation. Otherwise, all the training including organization improvement and excellent services behavior would be useless as they would be disappeared within 3 to 6 months. In the process of quality improvement, any techniques can be utilized, depending on appropriateness with each kind of work, working level and personnel, such as quality control (QC), suggestion system, CQI, cross functional, quality assurance in nursing, ISO, re-engineering, etc. It is vital not to get confused that the process of quality improvement and any methods are different. Furthermore, each method has advantages, depending on each kind of work, level and personnel in the hospitals.

4. Empowerment for changing is the responsibility of the director and executive committee to find out the methods for stimulating and encouraging the officials to work continuously in quality improvement. A case on total quality management in the sampling hospitals reveals that if the leaders have no methods in supporting and stimulating the personnel in quality improvement continuously, the quality improvement would be only a short-term affair and then disappeared. Methods for empowerment are as follows. First, there needs a vivid administration and the officials can take part in it. Then, leadership must be built up in every level of personnel, and the director must be a good sample with high leadership. He must be ready to work with his fellows in every condition. Besides, a qualitative teamwork must be set up, and there needs decentralization so that the officials have the full rights and power to decide by themselves at the proper level. Finally, the pattern of organization must be changed from the vertical one into the matrix one.

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5. When the hospitals have developed each dimension of work, the self evaluation system is needed in order to develop continuously and deeply into all personnel. It must a value that continuous quality improvement is a usual aspect, and the organization must conduct it usually and forever. If the current can be set up, any new techniques or names in quality improvement can be brought into the hospitals constantly, without any feelings that they are new. The personnel would feel that they are only the new methods. Approaching this stage, the hospitals would be one of learning organization. They would be qualitative and able to adjust with the new changes in the future under the globalization and rapid changes.

Jirut Srirattanaball and others (1998:71-73) suggest some interesting features for wandering to hospital accreditation by summarizing from the case study from the sampling public hospitals in quality improvement by total quality management as follows.

1. Regarding leadership commitment, the senior executive committees must be strict about quality and pay attention to it continuously. They must lead by example, be interested and have good attitudes towards quality improvement.

2. In strategic planning, policy direction and work instruction would help build up effort among personnel in the hospitals. Then, the organizational goal is clear.

3. About process management, the hospitals with rapid progress would employ the quality policy as the main one, and they would assign every department about the activities for quality improvement.

4. The important factor that makes the total quality management project successful is that all officials must realize the importance. Moreover, the executive committees would also realize the essence and support them, as well as organizing training for understanding total quality management. The factor that makes total quality management failure is that the officials do not pay attention to it. Furthermore, the executive committees do not support, understand total quality management, and there is no training.

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5. The operation which possibly succeeds may derive from these factors.

5.1 The strategy and method in quality improvement of the hospitals must be clear so that they would be employed to the practicality easily, and the organization as well as the personnel has the same direction.

5.2 The crucial input factors are the establishment of good attitudes among every executive committee, especially with the doctors. They must have good knowledge and right comprehension about quality improvement.

5.3 There must be an appropriate cultural adjustment especially on the attitudes towards operation, colleagues and services, with an emphasis on system and process changes. Moreover, clear evaluation on quality improvement is necessary so that the results would be concrete, especially on the features that influences upon the patients. Both internal and external customers' satisfaction is emphasized.

In conclusion, regarding the preparation for hospital accreditation, preparation on personnel's readiness is the first priority. An emphasis is put on changing the attitudes and readiness of the personnel towards each aspect of quality improvement. Awareness on the necessity of quality improvement must be built up among the personnel in the hospitals, from the director to the officials. They must believe that quality improvement would bring about a better and easier operational system. The officials would work under the lowest risk, and the approaches and the goals of quality improvement must be conveyed to them. They must know and comprehend quality improvement in the same direction. There are several basic methods for changing the personnel's attitudes such as organization development (OD), excellent services behavior (ESB). The ultimate goals are that the personnel would love and co-operate. They must be ready to service the customers. These are the changes in attitudes, social values and operational behaviors. They must be able to work with the others, accept the group's opinions, decrease the unacceptable behaviors, and accept the conflicts in opinions. These are fundamental in team building and policy direction. Good cooperation and teamwork comprise of the team within the organization, cross functional team and team between professions. Then synergy from

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everybody and every department is created in order to build up success in quality improvement.

From the review of literature on approaches in readiness preparation for hospital accreditation together with approaches on quality improvement and those of readiness and attitudes, the researcher can summarize that the following features are necessary for quality improvement of the hospitals: comprehension on quality improvement, good attitudes, awareness on quality improvement, support, participation, good co-ordination, teamwork and patient-centered. How ready in quality improvement the personnel of the hospitals are depends on the organizational new cultures, leadership and personal differences.

2.3.4 Problems in hospital accreditation operation

Quality improvement for accreditation is not easy. It consumes time, and there exists several problems. The ones which frequently occur are as follows (Gardner and Cumming, 1994:63-64; Suppachai Kunarattanapruek, 1995:4; Anuwat Suppachutikul, 2000:93).

1. The hospitals tend to response the officials' needs rather than those of the customers.

2. There is no co-operation from the officials. The executive committees do not participate and the senior ones are not sincere with it.

3. As the quality improvement activities take time, it seems to increase the workload and time at the first stage.

4. The governmental system does not comfort the problem solution. The rules regulations are the obstacles that make the operational officials unable to state out their opinions.

5. There are no changes in the thinking and working methods. Traditional problem solving methods and typically operational cultures are still employed.

6. The leaders always command and control rather than giving an opportunity for the group to decide.

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7. The executive committees oppose and the physicians do not participate.

8. There is insufficient perception on quality improvement training.

9. There is no information about the customers' quality needs, nor is there a center to support the group to function systematically.

10. There is no continuous quality improvement.

Besides, Anuwat Suppachutikul has stated about the five operational steps for hospital accreditation: awareness, learning, quality assurance establishment, continuous quality improvement and usual co-operation. As this study is the basic research to study personnel's readiness for quality improvement, the problems in the first two stages, the awareness and the learning, that are gathered by Anuwat Suppachutikul (1998:76-77) are as follows.

1. In the awareness stage, the leaders are very important. The favorite characteristics of the leaders are acceptance, understanding and humor. The leaders should be the first ones who study about what they would receive from quality improvement and what they have to do. The most common problems are as follows.

- The leaders think that they understand quality improvement, but they do not. Moreover, nobody can talk to them.

- The leaders assign somebody to conduct the process.

- The leaders think that quality improvement is just a project in trend. They do not think that it would really change organizational cultures.

- The leaders understand what quality improvement is, but they do not know their roles.

2. The learning stage is the one which the officials face several new activities, so they may easily get confused. The coordinator or helper who can advise them is really necessary. The most frequent problems at this stage are as follows.

- There are not any coordinators or the officials in the quality improvement center who can work full-time.

- It takes a very long time to build up obligation and the visions. Moreover, when they are already created, they are not used for improvement.

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- After the survey on the improvemental environment and the customers' needs, they are not analyzed for finding the solutions.

- There is a team building activity, but there are no follow-up activities to utilize the team's capability.

The first thing which is the most essential in quality improvement is that the organization must be trusted by the officials. The leaders must have an obvious standing point, and the efforts of everybody in the organization would be in the same direction. This would take place only if every level of organizational leaders and all officials want to change the organization.

From the review of the literature and the obstacles taken place from the operation of quality improvement, it indicates that there are a lot of factors concerning the success of quality improvement in the hospitals. These are considered the conditions of success in quality improvement of the community hospitals and divided into three important aspects as follows.

1. The organizational leader or the director must have leadership, visions and a clear standing point in solving the organizational problems. They must pay a real attention to continuous quality improvement and understand quality improvement. They must be able to convey their opinions and the improvemental goal to everybody so that the efforts of all personnel are in the same direction. They must build up leadership in every level of executive committees and every level of personnel by empowerment them through training, providing them knowledge and giving the opportunity to solve the problems or improve work. Furthermore, the new opinions should be applied to improve work and importance should be put on brainstorming for decision making. In quality improvement, they must motivate, stimulate and encourage the personnel as well.

2. New cultures must be created in the organization by paradigm shift. These cultures must also build up co-operation in improvement and problem solution. Officials have the opportunities to express their opinions by decentralization, participation and empowerment in order to build up more power for changing. These would lead to co-operational work from everybody, every group and every department

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(social engagement), and they would learn and decide to solve the problems together. The emphasis would be put on solving the problem and improving the operational process or system rather focusing on an individual. The mistakes or failures must be analyzed to find out the weak point and the new operational methodology which can response both internal and external customers' needs (customer focus).

3. Every aspect of personnel's readiness for quality improvement in the hospitals such as comprehension, attitudes, awareness, support, participation, co-operation, teamwork and patient-centered operation, can happen under the condition of the new organizational cultures, the leadership and the personal differences among the personnel of the hospitals.

2.4 Relevant Literature

A. Relevant Literature on Readiness

There exist no studies on personnel's readiness for quality improvement in the community hospitals; therefore, the researcher has gathered the relevant documents and researches that concern personnel's readiness for quality improvement in the hospital as follows.

From the review on approaches and theories about readiness and attitudes, Carter (Carter VG, 1945:37) defines attitudes as the readiness trend to express out in either support or oppose way towards a situation, a person or something. Prapapen Suwan (1983:1, 3-14) state attitudes or opinions of a person concern with opinions, feelings and understanding towards that situation. In evaluating state of readiness of a person to response a situation or stimulant, Good (1973:472) expresses that readiness means the ability to decide, the desire and the ability to participate in the activity. Arthorn Yaowapranee (1977:49) defines readiness as the condition that occurs within an individual and forces him to do something that he thinks might be successful. From the review on approaches and theories about readiness and attitudes, although there is no evidence about what readiness concerns, the researcher can conclude from the analysis that any condition of readiness of a person composes of good comprehension

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and attitudes towards that thing or situation. It will bring him to support or participate so that the activity he is doing can be successful.

Besides, from the review on the approaches and theories about quality improvement, and preparation for readiness for hospital accreditation, the Hospital Accreditation Institute (2000:4) and many academies summarize that in hospital accreditation, the emphasis is on quality process that is dynamical and gathering everybody's intention. The fundamental belief is that quality derives from each person's commitment, teamwork operation, patient-centered activities and standardized working system with a continuous improvement. There also needs improvement on behaviors and attitudes so that every person's capacities can be elicited and fully utilized. Moreover, all employees must involve in the quality improvement process, and it must be a part of operation (Thida Ningsanont, 1999:9-10; Witoon Simachokedee, 1998:38-54; Anuwat Suppachutikul, 1998:49-50; Deming WE, 1986 cited in Anuwat Supachutikul, 2000:29-30). After analyzing it with the theories on readiness and attitudes, the researcher can conclude that in quality improvement of the hospitals, personnel must be ready in comprehension about quality improvement, have a good attitude towards quality improvement, as well as commit, support, participate and assist in patient-centered teamwork for the success.

Chatree Banchuen (1998:32-36) summarizes the main features from the experiences of the sampling hospitals in the total quality management project. He claims that the first things necessary to conduct are to change the attitudes and readiness of the personnel for quality improvement, to build up awareness in urgency and necessity of improvement among the personnel of the hospitals, to make an understanding with all personnel about what the organization is doing and to establish commitment and the targeted goal together between the executive committees and the officials. These will lead to participation, good coordination and teamwork. In the meantime, Aongart Wiputsiri (2000:186) has studied and evaluated the total quality management project of eight sampling hospitals under the Ministry of Public Health. He finds that the three most essential factors causing a success or a failure in quality

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improvement are realization on the importance, participation of all personnel and the commitment and well support from the executive committees.

From the above review of literature as well as the logical analysis, readiness of the personnel is quality improvement of the community hospitals concern with comprehension about quality improvement, good attitudes, awareness on quality improvement, support from the executive committees, participation from everybody in the organization, co-operation, teamwork and patient-centered operation. The ultimate goal of improvement is to service people qualitatively, so for successful quality improvement, the personnel must be ready in these aspects: comprehension, attitudes, awareness, support, participation, teamwork and patient-centered operation.

B. Relevant Documents and Research about Variables

As there are no previous studies on personnel's readiness for quality improvement in the community hospitals, the research has gathered the relevant researches in order to study the factors influencing personnel's readiness for quality improvement namely personal factors and organizational factors. The researcher expects these factors would influence personnel's readiness for quality improvement in the hospitals as follows.

2.4.1 Personal Factors

Age

Age is a personal characteristic that differentiates each individual in knowledge, attitudes and behaviors as persons of different ages would have different needs and attitudes (Preeyaporn Wonganutrarot, 1992:67). Regarding the theories on social and cultural changes in accepting new things, Somsak Santisuk (1983:29) states that the people with 20-50 years of age tend to accept new things better than those with more than 50 years of age. Anongnart Kongkanoy (1995:115) studies on the readiness in consulting about AIDS of the public health officials working for the district health centers and the community hospitals in Pitsanulok and finds that age relates to

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readiness in knowledge about AIDS of the officials. Wanpen Siriprakaisilp (1996:29-30) studies the abilities in defending hypertension of the public health volunteers in Supanburi and finds that different ages of the volunteers result in the abilities in defending hypertension. Ones who are less than 30 years of age and who are between 30 and 50 years of age tend to have better abilities than those with more than 50 years of age.

In this study, consequently, the researcher has set up a hypothesis that different ages result in different levels of readiness for quality improvement of the personnel in the community hospitals.

Educational Level

Education is a constituent that helps an individual be capable and able to adjust himself to the surroundings. Persons with good education would be more creative, reasonable and comprehensible than those who have lower education. Different educational levels somewhat tend to influence people's improvemental abilities. Siriwan Wachirawong (1993:abstract) studies the factors that influence readiness in controlling and preventing hypertension of the public health officials in Supanburi and finds that the highest educational level positively relates to readiness in operation. Anchana Wongpataradee (1994:abstract) studies the functional abilities of the public health volunteers working in the community health centers in Buriram and states that the educational level relates to the functional abilities.

In this study, the researcher has set up a hypothesis that different educational levels result in different levels of readiness for quality improvement of the personnel in the community hospitals.

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Marital Status

Marital status is a factor possibly influencing personnel's readiness for quality improvement in the hospitals. Nittaya Ratsameerat (1977, citen in Suwannee Rodbamrur, 1991:47) studies the relationship between satisfaction in work and work efficiency with a case study in family planning officials at the public health centers in Bangkok. She finds that the marital status of the officials results in work efficiency. Wanpen Tangsasom (1989:abstract) studies the influences of personal status, functional abilities and leadership upon operational classification of the leaders of the public health center. The results indicate that marital status influences functional abilities. The single officials tend to have the better functional abilities than those with other marital statuses.

In this study, the researcher has set up a hypothesis that different marital statuses result in different levels of readiness for quality improvement of the personnel in the community hospitals.

Income

Income means the salary included with other incomes. Siriwan Wachirawong (1993:abstract) studies the factors influencing readiness in controlling and preventing hypertension of officials working in the public health centers in Supanburi and finds that the best factors that can predict changes in readiness in operation in salary. Wanida Weerakul (1991:abstract) studies the readiness of volunteers in population study activities in Khonkaen and finds that income relates to readiness of the volunteers in conducting the persuasion activities.

In this study, the researcher has set up a hypothesis that different incomes would result in different levels of readiness for quality improvement of the personnel in the community hospitals.

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2.4.2 Operational Factors

Position

Positions can be divided into the executive committees and the officials. The executive committees refer to the doctors and the leaders of each group, department and ward.

Positions mentally affect the officials as they guarantee security in life and work. Officials with a high position would feel save. Work security would result in satisfaction and morale as well as operational behaviors beneficial to the organization (Ferrans & Power, 1985 cited in Chanakarn Boonnoot, 1997:24). From the study of Slocum and others (1972 cited in Sasiwan Wachirawong, 1993:53), it is found that regarding work security, the officials with a higher position would be more satisfied then those with a lower position. Therefore, positions possibly affect personnel's readiness for quality improvement.

In this study, the researcher has set up a hypothesis that different positions would result in different levels of readiness for quality improvement of the personnel in the community hospitals.

Types of Personnel

Personnel in the hospitals can be classified into three categories namely the doctors and dentists, the nurses and the other officials. That an individual or a group of people accepts new things that lead to changes relates to personalities, knowledge and comprehension, attitudes and social values of each individual or group. Each group would have the norms that assign the behavioral boundaries of the group's members. Therefore, the norm also affects acceptance or rejection to that innovation (Rogers and Shoemaker, 1971 cited in Tapthip Thitipongpanich, 1996:50). From a presentation and experiment on TOM/CQI with the hospitals in the USA, it is found that one-tenth of the obstacles and problems in the quality improvement process of the hospitals are that it is hard to convince the doctors to participate in. However, if it is done, the quality improvement process tends to be highly successful. In addition, in utilizing TQM/CQI for developing the quality of the hospitals under the Ministry of Public Health, an

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essential problem is that there is no co-operation from the officials, and that some doctors do not accept (Anuwat Supachutikul, 2000:92-93).

In this study, as a result, the research has set up a hypothesis that different types of personnel affect different levels of readiness for quality improvement of the personnel in the community hospitals.

Duration in Professional Operation

Duration in professional operation means the number of years that the sampling personnel have worked on the current profession. This would result in different levels of professional skills and experiences as well as those of attitudes and readiness in operational readiness because attitudes are the mental condition caused up by experiences. This condition makes a person to response to the goal, approach or situation (Ernest et.al., 1971:523; Preeyaporn Wonganutrarot, 1992:64). Anchalee Mulada (1998:abstract) studies on the readiness in public health planning of the planning leaders and the responsible officials who work in the offices of public health in every province except Bangkok. She finds that the duration in professional operation of the officials positively relate to readiness in public health planning.

In this study, the researcher has set up a hypothesis that different duration of professional operation would result in different levels of readiness for quality improvement of the personnel in the community hospitals.

Training Experience

Training experience reveals to the status that the samples have ever or never been trained about quality improvement. Training is a process in changing behaviors systematically so that the personnel would have knowledge, skills and attitudes that are necessary for operation, with an emphasis on good operation both at the present time and in the future. Training must be conducted in order to solve the organizational problems or to enhance the capacities in problem-solving and attitudes of the personnel in improving work as the organization appoints so that the organization can reach the established goal (Patcharee Neeranatkomon et. al. 1989:396-398; Sanoh Tiyao, 1984:127). Soontorn Kongthong (1984:abstract) studies on the factors that affect

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professional operation of the public health volunteers in Nakornsawan in the basic public health project of the Ministry of Public Health. He finds that training for operation relates to functioning as a volunteer. Orachorn Somsa-ard (1996:abstract) studies the level and factors influencing people's participation in the water bank project from a case study in Surin and finds that being trained about clean water affects the level and people's participation in the project process. Kanokwan Mukdasanit (1998:abstract) studies about studies about the relationship between personal characteristics, motivation and role perception and basic public health operation of personnel in the municipal health center. She finds that training experience relates to the basic public health operation in the municipal health center.

In this study, the researcher has set up a hypothesis that different training experiences result in different levels of readiness for quality improvement of the personnel in the community hospitals

Informational Perception

Informational perception reveals to the status that personnel have an opportunity to perceive the information about quality improvement via various methods such as a declaration on quality policy by the senior executive committees, a meeting, published materials, informational boards, or other media within the organizations. Siriwan Wachirawong (1993:abstract) studies the factors affecting readiness in controlling and preventing hypertension of the public health officials in Supanburi. She finds that higher opportunity in informational perception on hypertension positively relates to operational readiness. Moreover, it is also the third best factor that can forecast changes in operational readiness. Panomsri Saosarn (1989 cited in Suwannee Rodbamrur, 1991:50) studies on the behaviors in preventing AIDS amongst prostitutes in Bangkok and states that the informational level and the opportunities in informational perception are that factors that more highly relate to behaviors in preventing AIDS than other factors.

In this study, hence, the researcher has set up a hypothesis that different levels of opportunities in informational perception result in different levels of readiness for quality improvement of the personnel in the community hospitals.

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2.4.3 Factors about opinions towards the Characteristics of Organizations

Characteristics of organizational leaders

Organizational leaders reveal to the leadership of the directors of the community hospitals, that support or oppose to personnel's readiness for quality improvement of the community hospitals. The organizational leaders, which refer to the directors, must have leadership which is a process that the leaders use their power in convincing or guiding their officials to function in the way so that the organization would approach the appointed goal under the appointed situation (Boonmun Thanasuppawat, 1994:100; Arun Raktham, 1980:195).

A good leader must make everyone dream together, have the same ideas and try to achieve the goal. He, therefore, is the most crucial person to bring the approaches in quality improvement by TQM/CQI into practice, and he is the one who makes the organization successful by studying comprehensively, being the good sample, supporting and improving the managerial system to facilitate the continuous improvement as well as motivating, stimulating the personnel to be dynamic in quality improvement (Worapat Poocharoen, 2000:29-30; Anuwat Suppachutikul, 1998:50).

Moreover, from the evaluation of the eight sampling hospitals under the Ministry of Public Health in the TQM project of Aongart Wiputsiri (1997 cited in Anuwat Suppachutikul, 2000:186-191), it is found that the hospitals in this project vary in the progress of quality improvement. The factor which affects the difference is the attention and continuity of the senior and junior executive committees. For instance, changing the director of a hospital may suppress the improvement for at least 6 months. Meanwhile, changing the directors of another two hospital results in operational postpone. However, changing the director of another hospital results in rapid improvement.

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Pattama Yimpong (1999:abstract) studies and finds that the leaders' behaviors relate to acceptance of the total quality management. Naiyana Seesuksan (1985:abstract) studies on the problems and obstacles of employing quality group into the manufacturing industry business in Thailand. She reveals that the vital obstacles in QC activities are that the executive committees do not really understand QC approaches, and that the officials are not ready to accept the QC managerial system. Moreover, Anuwat Suppachutikul finds that the obstacles at the first stage of quality improvement is that the leaders do not really understand quality improvement and they do not know their roles.

In this study, the researcher has set up a hypothesis that different leadership of the leaders results in different levels of readiness for quality improvement of the personnel in the community hospitals.

Characteristics of Organizational Cultures

Characteristics of organizational cultures reveal to the operational behaviors derived from the thinking methods, beliefs and social values of the personnel in the organization. They would make each single organization different, and result in either a positive or a negative way to the personnel's readiness for quality improvement in the community hospitals. These characteristics compose of decision making style, problem-solving style and servicing style. Each organization would have the beliefs, social values and symbols that influence the activities and behaviors of the organizational personnel. They would also create operational personalities of a person, and make him realize in the operational goal (Edwards A. Shils, 1961:119, cited in Sujin Sawangsri, 1999:27-28).

Consequently, quality improvement emphasizes on changing in organizational cultures. This means changing in the thinking methods, social values and beliefs that are accepted and treated such as authorization, centralization, top-down management into the new social values about democracy, humanization, decentralization, empowerment, participation and motivation (Krit Suebson, 1989:31; Chiaochan Arsuwattanakul, 1989:200-201; Anuwat Suppachutikul, 1999:P06).

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Williams (1944 cited in Sujin Sawangsri, 1999:162) states that quality is resulted by forces in organizational cultures. Cultures are the combination of social values and beliefs of all members in the organization. If the executive committees continuously support the officials to express their opinions, the personnel would be ready and the organization would be usually developed. Importance must also be put on personal differences in terms of abilities and operational methodology by being flexible, combining personal differences with the organizational goals. Accordingly the ISO 9002 quality management system can be applied effectively.

In coincidence, several academies also state that quality improvement will be continuous and firm only if there are changes in organizational cultures. People in the organization must change their thinking method (paradigm shift), accept the new operational philosophy and accept the qualitative cultures. Quality must be accepted as a part of work, and leadership must be built up in every level of executive committees. The leaders must not expect perfection, decide in every step, but they must provide the power and freedom in operation. Moreover, to provide a chance in creating and trying out new things would bring about some new methods that make working more efficient. Problems must be considered in terms of the system rather than an individual in order to build up cooperation in improvement and to find out the solutions. Everybody must participate in problem solving, and each is the internal customer for one another. He must find out the customers' needs and response them, then servicing external customers would be more agile (Bernadine & Russell, 1993:538; Deming WE, 1986 cited in Anuwat Suppachutikul, 2000:29-30; Thida Ningsanont, 1999:2-3).

From the above mentioned statements, the researcher can summarize that the characteristics of organizational cultures that affect personnel's readiness for quality improvement in the community hospitals are decentralization, problem-solving and the characteristics of servicing both internal and external customers.

Additionally, Atchara Suwan (1993:abstract) studies the school cultures and educational supervising in the secondary schools in the first academic zone. She finds that the school cultures considerably relate to educational supervising. La-ead Makchaineramit (1995:abstract) studies the school cultures and instructional operation in the primary schools in Phuket and finds that the school cultures relate to the

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instructional operation of the teachers in these schools. Therefore, organizational cultures should also affect personnel's readiness for quality improvement of the hospitals.

In this study, the researcher has set up a hypothesis that different characteristics of decision making, problem solving, and servicing the customers result in different levels of personnel's readiness for quality improvement of the community hospitals.

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CHAPTER 3
METHODOLOGY

This study is a survey research in order to investigate the level of personnel's readiness and factors influencing personnel's readiness for quality improvement in community hospitals in Nakhonchaisi District, Nakhonpathom Province. The questionnaires are also employed in this study, and the researcher has learnt from the related document, texts and researches and summarized them in order to appoint the boundaries in this study as follows.

3.1 Studied Population

The population of this study is the personnel who are governmental officials working in each department of three community hospitals in Nakhonchaisi, Nakhonpathom, namely, Huayplu hospital, Luangporpern hospital and Nakhonchaisi hospital.

3.2 Size of Population and Selection

The targeted population of this study is 198 governmental officials really working for three community hospitals namely, Huayplu hospital, Luangporpern hospital and Nakhonchaisi hospital, excluding the directors of these hospitals.

The researcher selects the population by the census method in order to investigate the entire targeted population so that the findings can portray the real status the best. The population of each hospital can be classified as indicated in the first table.

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Table 1. The targeted population of each hospital

Hospital	Numbers of governmental officials
Huayplu hospital	81
- governmental official	79
- officer	2
Luangporpern hospital	50
- governmental official	48
- officer	2
Nakhonchaisi hospital	67
- governmental official	64
- officer	3
Total	198

Source: A telephoning interview of personnel officials, November 2000

3.3 Research Instruments

The research has constructed the questionnaires, employed as the research instrument, in order to collect the data for this study. The steps in instrumental construction are as follows.

1.The researcher studied about the approaches and theories on quality improvement of the community hospitals, the approaches on readiness preparation for the hospital accreditation and the problems in the quality improvemental operation of the community hospitals in order to synthesize them and utilize them as the essentially fundamental data for questionnaire construction so that the questionnaire can cover all variables in this research.

2. For the questions about the characteristics of the organizational leaders, the researcher applies from the criteria in evaluating the process in quality improvement of the hospitals by the Hospital Accreditation Institute (Anuwat Suppachutikul et. al., 2000:217), and merges it with the researcher's own analysis on the study of the problems about quality improvement process of the hospitals.

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3. For the questions about the personnel's readiness for quality improvement in the community hospitals, the researcher applies from the analytical format on the organizational environment of the Hospital Accreditation Institute (Anuwat Suppachutikul et. al., 1999: M02a1-3), together with the researcher's own analysis from the study on the approaches and the principles of quality improvement of the hospitals as well as the problems in the process of quality improvement in the hospitals.

The characteristic of the research instrument is the questionnaires, comprising of 4 parts as follows.

Part I is the questions about personnel factors, comprising of personal characteristics and operational characteristics such as age, educational level, marital status, income, position (executive committee/official), type of personnel, duration in professional operation, training experience and informational perception on quality improvement. The questions comprise of both open-ended and close-ended ones.

Part II is the questions about the opinions towards the organizational characteristics as follows.

2.1 The characteristics of the organizational leaders

2.2 The characteristics of the organizational cultures

These questions are close-ended, and they use the 3 levels of the rating scale in evaluating the personnel's opinions towards the characteristics of the organizational leaders and cultures within the hospitals, which support or oppose to the personnel's readiness for quality improvement. There are 30 questions, either positive or negative, that can be divided into 2 parts as follows.

- There are 14 positive questions, numbered 1-14, about the characteristics of the organizational leaders.

- There are 16 questions, numbered 1-16, about the characteristics of the organizational cultures. Thirteen questions of these are positive; meanwhile, the other three are negative, which are numbered 9, 10 and 11.

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The scoring criteria are the 3-level rating scale as follow.

		Positive statement	Negative statement
High	rating	3	1
Average	rating	2	2
Low	rating	1	3

The criteria for evaluating and classifying the characteristics of the organizational leaders and cultures divide the scores into 3 levels, regarding the arithmetic means plus or minus the standard deviation (Mean ± S.D.), and the criteria in classifying are as follows.

The characteristics of the organizational leaders (the total score is 42)

Less than twenty-three is the score which indicates the characteristics of the organizational leaders in the low level.

Twenty-three to thirty-five is the score which indicates the characteristics of the organizational leaders in the average level.

More than thirty-five is the score which indicates the characteristics of the organizational leaders in the high level.

The characteristics of the organizational cultures (the total score is 48)

Less than twenty-four is the score which indicates the characteristics of the organizational cultures which support the personnel's readiness in the low level.

Twenty-four to thirty-six is the score which indicates the characteristics of the organizational cultures which support the personnel's readiness in the average level.

More than thirty-six is the score which indicates the characteristics of the organizational cultures which support the personnel's readiness in the high level.

Part III of the questionnaires are the questions about personnel's readiness for quality improvement in the hospitals, considering from each aspect of personnel's readiness such as comprehension, attitudes, awareness, support, participation, co-ordination, teamwork and patient-centered operation.

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These questions are close-ended, and they employ the 5-level rating scale in evaluating the situation of operational level. The samples must answer the questions with one of these answers: the most, much, average, a little or the least (Supap Wadkien, 1982:34). There are 49 questions, either positive or negative, which can be divided into 8 parts as follows.

1. There are 7 questions about comprehension, numbered 1-7.
2. There are 5 questions about attitudes, numbered 8-12.
3. There are 6 questions about awareness, numbered 13-18.
4. There are 7 questions about support from the executive committees, numbered 19-25.
5. There are 6 questions about participation, numbered 26-31.
6. There are 5 questions about co-ordination, numbered 32-36.
7. There are 7 questions about teamwork, numbered 37-43.
8. There are 6 questions about patient-centered operation, numbered 44-49.

Forty-four questions of these are positive; meanwhile, five of them are negative, numbered 2, 14, 23, 26, 36. The scoring criteria are the 5-level rating scale as follows.

		Positive statement	Negative statement
The most	rating	5	1
Much	rating	4	2
Average	rating	3	3
A little	rating	2	4
The least	rating	1	5

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The criteria for evaluating the personnel's readiness for quality improvement in the hospitals

The criteria for evaluating and classifying personnel's readiness for quality improvement in the community hospitals divide the scores into 3 levels, regarding the arithmetic means plus or minus the standard deviation (Mean ± S.D.) , and the criteria in classifying are as follows (The total score is 245).

The score less than 140.4 is the one that indicates the low level of personnel's readiness for quality improvement in the hospitals.

The score between 140.4 and 188.6 is the one that indicates the average level of personnel's readiness for quality improvement in the hospitals.

The score more than 188.6 is the one that indicates the high level of personnel's readiness for quality improvement in the hospitals.

Part IV of the questionnaires is the questions on opinions and suggestions in the process of quality improvement in the community hospitals. They are both open-ended and close-ended so that the samples can answer these questions deliberately.

3.4 The Instrumental Quality Investigation

The instrument in this research is the questionnaire. After the researcher has constructed it, the process on quality investigation is conducted by the following methods.

1. The instrument must be investigated on its content validity by the advisor and the experts in order to check whether the questionnaires' contents are valid and whether they cover the points in the study.

2. The checked instrument would be improved and re-proposed to the advisor in order to investigate its content validity.

3. The instrument would be tried out with the samples which are similar to the targeted population. These samples are 30 personnel at Dontum hospital in Dontum District, Nakhonpathom. The results, then, are analyzed in terms of reliability by the Coefficient Alpha Cronbach method in which the formula is shown here. (Prakong Kannasoot, 1985:43)

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$$\alpha = \frac{n}{n-1}\left[1-\frac{\sum s_i^2}{S_x^2}\right]$$

when α is the reliability of the questionnaires.

n is the number of questions in the questionnaire.

S_i^2 is the fluctuation of each item's score.

S_x^2 is the fluctuation of the entire score or the standard deviation of the entire score, to the power of two.

The results of the reliability investigation of the questionnaires reveal the scores as follows.

- Questions about the characteristics of the organizational leaders have the reliability score as 0.92
- Questions about the characteristics of the organizational cultures have the reliability score as 0.77
- Questions about comprehension have the reliability score as 0.70
- Questions about attitudes have the reliability score as 0.84
- Questions about awareness have the reliability score as 0.70
- Questions about support have the reliability score as 0.75
- Questions about participation have the reliability score as 0.74
- Questions about co-ordination have the reliability score as 0.78
- Questions about teamwork have the reliability score as 0.79
- Questions about patient-centered operation have the reliability score as 0.87

It can be summarized that the questionnaires are reliable to investigate the characterisitics of the organizational leaders, the characteristics of the organizational cultures and personnel's readiness for quality improvement as appointed by the objectives of this study.

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3.5 Informational Collection

The researcher has submitted the letter indicating the purposes of the study and the informational collection methodology to the directors of all the three community hospitals in Nakhonchaisi, Nakhonpathom in order to ask for their permission and cooperation from the personnel in answering the questionnaires. The researcher herself has sent and collected the questionnaires, then all the questionnaires are checked about their completion before being analyzed.

3.6 Data Analysis

The data gathered from the samples are arranged in order to be encoded. Then, they are computerized by the SPSS (Statistical Package for the Social Sciences) program.

In the regression analysis, the appropriate variables should be continuously measured. If they are not measured continuously, the analysis needs to make the independent variables the dummy ones. These independent variables which need to become dummy table are educational level, marital status, position, type of personnel, duration in professional operation, and informational perception on quality improvement. The details are indicated in Table 2.

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Table 2 indicates the dummy variables of the studied independent variables.

Variables	Dummy Variables		
	X_1	X_2	X_3
Educational Level			
Low than Bacherlor's degree	0	-	-
Bachelor's degree or higher	1	-	-
Marital Status			
Single	1	0	-
Married	0	1	-
Divorced/ Separated/ Lost	0	0	-
Position			
Executive Committee	0	-	-
Operational Official	1	-	-
Type of Personnel			
Doctor/ Dentist/ Pharmacist	1	0	-
Professional Nurse/ Technical Nurse	0	1	-
Academy/ Public Health Officer and others	0	0	-
Duration in Professional Operation			
Less than 5 years	1	0	0
5-10 years	0	1	0
11-15 years	0	0	1
More than 15 years	0	0	0
Training Experience in each aspect			
Inexperienced	0	-	-
Experienced	1	-	-
Informational Perception on Quality Improvement			
A lot	0	0	-
Average	0	1	-
A little	1	0	-

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3.7 Statistics in Data Analysis

1. The analysis on the general characteristics of the samples together with the presentation employs the percentage, the arithmetic means and the standard deviation.

2. In the analysis on the differences between the independent variables and personnel's readiness for quality improvement in the community hospitals, the t-test is used if there are no more than 2 groups of variables, and the ANOVA is utilized if there are more than 2 groups of variables.

3. The Stepwise Multiple Regression Analysis is employed in the analysis on the factors influencing personnel's readiness for quality improvement in the community hospitals.

4. In this study, the statistical significance is at the 0.05 level.

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CHAPTER IV
RESULTS

In the study on personnel's readiness for quality improvement in the community hospitals in Nakhonchaisi district, Nakhonpathom province, the researcher employs the census method to select the population. Then, 198 targeted samples who are the government officials in the 3 community hospitals, namely Huayplu hospital, Luangporpern hospital and Nakhonchaisi hospital are studied. The questionnaire is distributed to the samples, and 191 of them (96.46%) is returned. Divided into 6 parts as follows, the findings of this study are presented in the tables together with the description.

4.1 General characteristics of the studied population

4.2 Findings of the opinions of the studied population about characteristics of organizational leader and cultures.

4.3 Findings of personnel's readiness for quality improvement in the community hospitals

4.4 Analytical results of the differences in personnel's readiness for quality improvement in the community hospitals, classified by the factors

4.5 Analytical results on the influences of the factors upon personnel's readiness for quality improvement in the community hospitals

4.6 Findings of the obstacles and problems in quality improvement of the community hospitals

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4.1 General characteristics of the studied population

According to the analysis on the data of the studied population, it is found that:

The studied population's average age is 32 years, with the standard deviation of 6.9. The youngest one is 21 years, and the oldest one is 58 years. Most of them (38.3%) is between 25 and 32 years, followed by the ones of 33-39 years (27.2%), the ones of less than 25 years (18.3%), and the one of more than 39 years (16.3%) respectively. (Table 3)

Most of the studied population (48.2) are married. However, 45.5 percent of them is single, and 6.3 percent is divorced or separated. (Table 3)

Regarding the educational level, most of the studied population finished their Bachelor's degree (64.9%), followed by the ones who received a certificate (24.6%), the ones who received a lower degree than a certificate (6.3%), and the ones who graduated a Master's degree (4.2%) respectively. (Table 3)

Besides, the studied population earns about 12,718.5 baht a month averagely. Most of them (42.9%) earn about 7,500 - 12,000 baht monthly, followed by the ones who earn 12,001 - 19,500 baht monthly (34.01%), the ones who earn less than 7,500 baht monthly (13.1%), and the ones who earn more than 19,500 baht monthly (9.9%) accordingly. (Table 3)

Regarding their positions, about 75.4 percent of the studied population are the operational officials; meanwhile, another 24.6 percent of them are the executive committees. (Table 3)

According to the analysis, most of the studied population (59.2%) is the professional nurses or technical nurses. Then, other officials such as pharmacy officials, dental officials, physical therapists are about 22.0 percent. Moreover, 7.9 percent of them are the public health officials; 5.2 percent of them are the doctors and the dentists; 3.7 percent of them are the pharmacists; and the academy officials are about 2.1 percent respectively. (Table 3)

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Regarding the duration in professional operation, it is found that most of the studied population (35.1%) has worked for 5-10 years, followed by the ones who have worked for less than 5 years (25.1%). Then, the ones who have worked for more than 15 years are about 24.6%, and the ones who have worked for 11-15 years are about 15.2% respectively. (Table 3)

Considering perception in quality improvement information, most of the studied population (52.4%) receives an average information that is about once or twice a month. Then, 28.2% of them receive much information that is more than twice a month. Besides, about 19.4% of them state that they receive a little information that is less than once a month or never. (Table 3)

Table 3 indicates the numbers and percentage of the studied population classified by the personal and operational factors

Factors	Studied population	
	Number	percentage
The total number	191	100.0
Age ($\bar{X}$ = 32.5, S.D. = 6.95, Max = 58, Min =21)		
less than 25 years	35	18.3
25 - 32 years	73	38.2
33 - 39 years	52	27.2
more than 39 years	31	16.3
Marital Status		
Single	87	45.5
Married	92	48.2
Divorced/ Separated	12	6.3
Educational Level		
Lower than a certificate	12	6.3
Certificate	47	24.6
Bachelor's degree	124	64.9
Master's degree	8	4.2

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Table 3 indicates the numbers and percentage of the studied population classified by the personal and operational factors (continued)

Factors	Studied population	
	Number	percentage
Income ($\bar{X}$ = 12,718.5, S.D.=5,636.2, Max = 40,000, Min = 5,000)		
Less than 7,500 baht	25	13.1
7,500 - 12,000 baht	82	42.9
12,001 - 19,500 baht	65	34.1
More than 19,500 baht	19	9.9
Position		
Executive Committee	47	24.6
Operational Officers	144	75.4
Type of Personnel		
Doctor/ Dentist	10	5.2
Professional/ Technical Nurse	113	59.2
Pharmacist	7	3.6
Academies	4	2.1
Community Public Health Officials	15	7.9
Others	42	22.0
Professional Operation		
Less than 5 years	48	25.1
5 - 10 years	67	35.1
11 - 15 years	29	15.2
More than 15 years	47	24.6
Perception on Quality Improvement Information		
Little (less than once a month or never)	37	19.4
Average (once or twice a month)	100	52.4
Much (more than twice a month)	54	28.2

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Regarding training experience, it is found that most studied population (91.6%) has undergone a training in organizational development (OD.). Moreover, 88% has passed a training in Five Ss activities; 67.5% has undergone a training in teamwork operation. Additionally, there is 26.7% of the population who has passed a training either in ESB or ISO, and 24.6% of them pass a training in hospital accreditation; 8.9% pass a training in QCC, CQI or TQM, and there is 8.4% of them who undergo a training in the 9 items of Gen. respectively. (Table 4)

Table 4 indicates the number and percentage of the studied population classified by the training experience

Training experience	Studied population	
	Number	Percentage
The total number	191	100.0
QCC/CQI or TQM		
Ever	17	8.9
Never	174	91.1
ISO		
Ever	51	26.7
Never	140	73.3
Quality assurance (QA)		
Ever	46	24.1
Never	145	75.9
Five Ss Activities		
Ever	168	88.0
Never	23	12.0
Organizational Development (OD.)		
Ever	175	91.6
Never	16	8.4

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Table 4 indicates the number and percentage of the studied population classified by the training experience (continued)

Training experience	Studied population	
	Number	Percentage
ESB		
Ever	51	26.7
Never	140	73.3
Teamwork Operation		
Ever	129	67.5
Never	62	32.5
Hospital Accreditation (HA)		
Ever	47	24.6
Never	144	75.4
9 Items of Gen.		
Ever	16	8.4
Never	175	91.6

4.2 Findings of the opinions of the studied population about characteristics of organizational leader and cultures.

The results of the study on the opinions of the studied population toward characteristics of organizational leader and cultures are as follows.

4.2.1 **Opinions of the studied population toward organizational leader.** The arithematic means of the characteristics of organizational leader equals 28.8; meanwhile, the standard deviation is 6.7. The minimum score is 15, and the maximum is 39. After dividing the scores on the characteristics of organizational leader into 3 categories namely the low, the medium and the high level by the criteria of the arithmetic means plus or minus the standard deviation (Mean $\pm$ S.D.), it is found that 18.3 % of the studied population think that the organizational leader has a high level of leadership in quality improvement. In the meantime, 23.6% of them state that the organizational leader has a low level of leadership. However, most of the studied

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population (58.1%) reveal that the organizational leader has a medium level of leadership. (Table 5)

Table 5 indicates the number and percentage of the studied population classified by the characteristics of the organizational leaders. (The total score is 42.)

The opinions of the studied population toward the characteristics of organizational leader	Studied population	
	Number	Percentage
The total number	191	100.0
The low level of leadership (less than 23 marks)	45	23.6
The medium level of leadership (23-35 marks)	111	58.1
The high level of leadership (more than 35 marks)	35	18.3
$\bar{X}$ = 28.8, S.D. = 6.7, Max = 39, Min = 15		

4.2.2 For the studied populations' scores on the opinions towards the characteristics of the organizational cultures, the arithmetic means is 30.8; the standard deviation is 6.8, and the minimum and maximum scores are 18 and 47 respectively. The score of the arithmetic means plus or minus the standard deviation (Mean $\pm$ S.D.) is then separated into 3 levels that are the low, the medium and the high ones. It is found that 12.6% of the population think that the organizational cultures in the community hospitals support personnel's readiness at the low level. Meanwhile, another 22.5% of them state that they support personnel's readiness at the high level. However, most of the population (64.9%) expresses that the organizational cultures in the community hospitals support personnel's readiness at the medium level. (Table 6)

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Table 6 indicates the number and percentage of the studied population classified by the characteristics of the organizational cultures. (The total score is 48.)

The opinions of the studied population toward the characteristics of organizational cultures	Studied population	
	Number	Percentage
The total number	191	100.0
The low level of organizational cultures (less than 24 marks)	24	12.6
The medium level of organizational cultures (24-36 marks)	124	64.9
The high level of organizational cultures (more than 36 marks)	43	22.5
$\bar{X}$ = 30.8, S.D. = 6.8, Max = 47, Min = 18		

4.3 Findings of personnel's readiness for quality improvement in the community hospitals

The average score on personnel's readiness in the community hospitals is 164.5. The standard deviation equals 24.1. In the meantime, the lowest score and the highest one are 113 and 230 orderly. According to the division of personnel's readiness for quality improvement of the community hospitals, most executive committees (53.2%) are at the average level on readiness, followed by the ones who are at the high level (36.2%) and the ones who are at the low level (10.6%) respectively. Meanwhile, most of the operational officials are at the average level on readiness (63.9%), followed by the ones who are at the low level (22.9%), and the ones who are at the high level (13.9%) respectively. Regarding the entire population, most of them are at the average level on readiness (61.8%), followed by the ones who are at the low level and the high level (19.9% and 19.4%) respectively. (Table 7)

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Table 7 indicates the number and percentage of the studied population classified by the levels of readiness for quality improvement. (The total score is 245.)

Personnel's readiness	Executive committees (N = 47)		Operational officials (N = 144)		Total (N = 191)	
	number	percent	number	percent	number	percent
High (more than 188.6)	17	36.2	20	13.9	37	19.4
Average (140.4 - 188.6)	25	53.2	91	63.2	116	60.7
Low (less than 140.4)	5	10.6	33	22.9	38	19.9
Total	47	100.0	144	100.0	191	100.0

$\overline{X}$ = 164.5, S.D. = 24.1, Max = 230, Min = 113

Considering each aspect of personnel's readiness by equalizing each base and dividing the score of each aspect with the numbers of questions, the scores are then separated into 3 levels that are the low, the average and the high ones on personnel's readiness. It is found that the executive committees are at the high level on readiness in two aspects that are attitudes and quality improvement awareness. They are at the average level in comprehension, support, participation, co-ordination, teamwork and patient-centered operation. Meanwhile, the operational officials are at the high level of readiness in only one aspect that is attitudes. They are at the average level of readiness in comprehension, awareness, co-ordination, teamwork and patient-centered operation. Additionally, they are at the low level in participation. Considering the whole population, the personnel of the community hospitals are at the high level in attitudes. They are at the average level in comprehension, awareness, support, co-ordination, teamwork, patient-centered operation, and they are at the low level in participation in quality improvement of the community hospitals. (Table 8)

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Table 8 indicates the arithmetic means, the standard deviation and the level of personnel's readiness in each aspect of the executive committees and the operational officials for quality improvement of the community hospitals (N = 191)

Personnel's readiness for quality improvement	Executive Committees (N = 47)			Operational Officials (N = 144)			Total (N = 191)		
	$\overline{X}$	S.D.	Level	$\overline{X}$	S.D.	Level	$\overline{X}$	S.D.	Level
1. Comprehension	3.7	0.6	Average	3.4	0.6	Average	3.5	0.6	Average
2. Attitudes	4.3	0.6	High	4.0	0.6	High	4.1	0.6	High
3. Awareness	4.0	0.6	High	3.7	0.6	Average	3.8	0.6	Average
4. Support	3.3	0.6	Average	3.2	0.9	Average	3.2	0.9	Average
5. Participation	3.2	0.7	Average	2.5	0.7	Low	2.7	0.7	Low
6. Co-ordination	3.5	0.4	Average	3.3	0.5	Average	3.4	0.5	Average
7. Teamwork	3.5	0.5	Average	3.0	0.6	Average	3.1	0.6	Average
8. Patient-centered Operation	3.3	0.7	Average	3.2	0.6	Average	3.2	0.6	Average

4.4 Analytical results of the differences in personnel's readiness for quality improvement in the community hospitals, classified by factors

4.4.1 The investigation on differences of personnel's readiness for quality improvement in the community hospitals, classified by the independent variables with more than 2 groups by One-way ANOVA yields the following results detailed in Table 9.

Regarding age, it is found that the population of more than 39 years are the most ready for quality improvement ($\overline{X}$ = 172.8), followed by the one of 33 - 39 years, of 25 - 32 years, and of less than 25 years respectively. According to the statistical analysis, different ages result in different scores in personnel's readiness for quality improvement without the statistical significance at the 0.05 level (P = 0.159).

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Considering marital status, the ones who are married are the most ready persons in quality improvement ($\overline{X}$ = 168.1), followed by the ones who are single and the ones who are divorced or separated respectively. Referring to the statistical analysis, the different marital status causes different scores in personnel's readiness for quality improvement with the statistical significance at the 0.05 level (P = 0.021). The groups with differences in the average scores of personnel's readiness are the married group and the divorced or separated one only.

Regarding the income, the population with more than 19,500 baht are the most ready in quality improvement ($\overline{X}$ = 180.6), followed by the one with 12,001 - 19,500 baht, the one with 7,500 - 12,000 baht and the one with less than 7,500 baht respectively. From the statistical analysis, different monthly income results in different scores in personnel's readiness for quality improvement with the statistical significance at the 0.05 level (P = 0.001). Moreover, every group is different in the average scores in personnel's readiness, except the group of less than 7,500 baht and the group of 7,500 - 12,000 baht, and the group of 7,500 - 12,000 baht and the one of 12,001 - 19,500 baht.

Considering types of personnel, the doctors, the dentists and the pharmacists are the most ready in quality improvement ($\overline{X}$ = 177.1), followed by the professional and technical nurses, the academies, the community public health officials, and the others respectively. Referring to the statistical analysis, the different types of personnel also result in different scores in personnel's readiness for quality improvement with the statistical significance at the 0.05 level (P = 0.022). The groups with the different scores are only the group of the doctors, the dentists and the pharmacists and the group of the academies and the community public health officials.

Regarding duration in professional operation, the officials who have worked for more than 15 years are the most ready for quality improvement ($\overline{X}$ = 174.5), followed by the ones who have worked for 5 - 10 years, the ones who have worked for less than 5 years and the ones who have worked for 11 -15 years respectively. According to the statistical analysis, the different duration in professional operation results in different scores in personnel's readiness with the statistical significance at the 0.05 level (P = 0.009). Besides, every group is different in scores in personnel's

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readiness, except the one of the officials who have worked for less than 5 years and for 5-10 years, the one of the officials who have worked for less than 5 years and 11-15 years, and the one of the officials who have worked for 5-10 years and 11-15 years.

Considering perception in quality improvement information, the officials who have received much information are the most ready for quality improvement ($\overline{X}$ = 185.7), followed by the ones who have received average and little information orderly. Referring to the statistical analysis, different perception in quality improvement information results in different scores in personnel's readiness with the statistical significance at the 0.05 level (P = 0.000). Furthermore, every group is different in the average scores of personnel's readiness with the statistical significance at the 0.05 level.

Concerning the studied population's opinions towards the characteristics of the organizational leaders, the population who thinks that the organizational leader has a high level of leadership is the most ready for quality improvement ($\overline{X}$ = 185.5). Then, the one who thinks that the organizational leader has an average level of leadership ($\overline{X}$ = 164.1) and a low level of leadership ($\overline{X}$ = 149.2) follow respectively. Statistically, the different characteristics of organizational leaders in quality improvement result in the different average scores of the personnel's readiness with the statistical significance at the 0.05 level (P = 0.000). Additionally, every group is different is the average scores in personnel's readiness with the statistical significance at the 0.05 level.

Regarding the studied population's opinions towards the characteristics of the organizational cultures, the population who thinks that the organizational cultures highly support personnel's readiness is the most ready for quality improvement ($\overline{X}$ = 190.3). Then, the one who thinks that the organizational cultures fairly support personnel's readiness ($\overline{X}$ = 159.7) and poorly support ($\overline{X}$ = 142.6) follow respectively. Statistically, the different characteristics of organizational cultures result in the different average scores of the personnel's readiness with the statistical significance at the 0.05 level (P = 0.000). Additionally, every group is different in the average scores in personnel's readiness with the statistical significance at the 0.05 level.

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Table 9 indicates the differences of personnel's readiness for quality improvement, classified by the independent variables of more than two groups, treated by One-way ANOVA

Independent variables and the groups	N	$\bar{X}$	S.D.	F-Ratio	P-value
The total number	191				
Age				**1.748**	**0.159**
Less than 25 years	35	160.6	21.6		
25 - 32 years	73	162.4	22.3		
33 - 39 years	52	164.9	26.7		
more than 39 years	31	172.8	25.2		
Marital status				**3.920**	**0.021**
Single	87	162.9	23.1		
Married	92	168.1	24.7		
Divorced/ Separated	12	148.5	20.3		
Monthly income (Baht)				**5.509**	**0.001**
Less than 7,500 baht	25	154.9	22.9		
7,500 - 12,000 baht	82	161.0	22.1		
12,001 - 19,500 baht	65	167.8	26.2		
more than 19,500 baht	19	180.6	17.1		
Types of Personnel				**3.910**	**0.022**
Doctors/ Dentists/ Pharmacists	17	177.1	24.5		
Professional/ Technical nurses	113	165.3	22.7		
Academies/ Public Health officials and others	61	159.3	25.3		
Duration in Professional Operation				**3.961**	**0.009**
Less than 5 years	48	159.9	21.8		
5 - 10 years	67	162.7	23.2		
11 - 15 years	29	159.7	26.6		
more than 15 years	47	174.5	23.7		

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Table 9 indicates the differences of personnel's readiness in quality improvement, classified by the independent variables of more than two groups, treated by One-way ANOVA (continued)

Independent variables and the groups	N	$\overline{X}$	S.D.	F-Ratio	P-value
Perception in Quality Improvement Information				**64.491**	**0.000**
Little perception	37	141.3	16.7		
Medium perception	100	161.5	19.0		
Much perception	54	185.7	19.2		
Characteristics of organizational leaders				**28.888**	**0.000**
Low level of leadership	45	149.2	19.2		
Average level of leadership	111	164.1	22.5		
High level of leadership	35	185.5	19.2		
Characteristics of organizational cultures				**59.797**	**0.000**
Low level of support	24	142.6	15.4		
Average level of support	124	159.7	20.0		
High level of support	43	190.3	17.4		

4.4.2 The investigation on differences of personnel's readiness for quality improvement of the community hospitals, classified by the independent variables with no more than 2 groups by t-test yields the following results detailed in Table 10.

Regarding the educational level, the officials with a Bachelor's degree or higher and the ones with a lower degree than Bachelor have the different average scores in quality improvement with the statistical significance at the 0.05 level (P = 0.000). The ones with a Bacherlor's degree or higher are more ready than the ones with a lower degree ($\overline{X}$ = 169.1 and 154.2 respectively).

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The different positions that are the executive committees and the operational officials also result in the different scores in quality improvement with the statistical significance at the 0.05 level (P = 0.000). It is found that the executive committees are more ready than the operational officials ($\overline{X}$ = 176.5 and 160.5 respectively).

The analytical results on the training experience are as follows.

The different training experiences between the officials who have ever undergone a QCC/CQI or TQM training and those who have never done result in different scores in personnel's readiness for quality improvement without the statistical significance at the 0.05 level (P = 0.090). The ones who have ever been trained score higher than the ones who have never been done ($\overline{X}$ = 173.9 and 163.5 respectively).

Meanwhile, the different training experiences between the officials who have ever passed a training in ISO and those who have never result in the different scores in personnel's readiness in quality improvement without the statistical significance at the 0.05 level (P = 0.347). That is the ones who have ever passed score slightly higher than those who have never ($\overline{X}$ = 167.2 and 163.4 respectively).

Additionally, the different training experiences in quality assurance(QA) also cause different scores in quality improvement. The scores of the ones who have undergone this training and those of the ones who have never are different without the statistical significance at the 0.05 level (P = 0.158). Moreover, the ones who have undergone this training score higher than those who have never ($\overline{X}$ = 168.8 and 163.1 respectively).

The different training experiences in the 5 Ss activities also result in the different scores in personnel's readiness for quality improvement without the statistical significance (P = 0.066). The officials who have passed a training in this program score pretty higher than those who have never ($\overline{X}$ = 165.6 and 155.8 respectively).

The different training experiences between the officials who have ever undergone an organizational development program (OD) and those who have never done result in different scores in personnel's readiness for quality improvement with the statistical significance at the 0.05 level (P = 0.021). The ones who have ever been trained score higher than the ones who have never been done ($\overline{X}$ = 165.7 and 151.2 respectively).

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Meanwhile, the different training experiences between the officials who have ever passed a training in ESB and those who have never result in the different scores in personnel's readiness for quality improvement without the statistical significance at the 0.05 level (P = 0.655). That is the ones who have ever passed score slightly higher than those who have never ($\overline{X}$ = 165.7 and 164.6 respectively).

The different training experiences in teamwork also result in the different scores in personnel's readiness for quality improvement with the statistical significance at the 0.05 level (P = 0.048). The officials who have passed a training in this program score higher than those who have never ($\overline{X}$ = 166.8 and 159.5 respectively).

Furthermore, the different training experiences in hospital accreditation also cause different scores in quality improvement. The scores of the ones who have undergone this training and those of the ones who have never are different without the statistical significance at the 0.05 level (P = 0.223). The ones who have undergone this training score higher than those who have never ($\overline{X}$ = 168.2 and 163.2 respectively).

Finally, the different training experiences in the self-evaluation of the hospital accreditation institute (Gen 9 items) bring about the different scores in quality improvement without the statistical significance at the 0.05 level (P = 0.265). The officials who have passed this program score higher than those who have never passed it ($\overline{X}$ = 170.9 and 163.9 respectively).

Table 10 indicates the differences in personnel's readiness for quality improvement, classified by the independent variables of no more than 2 groups by t-test.

Dependent variables	N	$\overline{X}$	S.D.	t-value	P-value
The total number	191				
Educational level				**-4.064**	**0.000**
Lower than a Bachelor's degree	59	154.2	21.5		
Bachelor's degree or higher	132	169.1	23.8		

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Table 10 indicates the differences in personnel's readiness for quality improvement, classified by the independent variables of no more than 2 groups by t-test. (continued)

Dependent variables	N	$\overline{X}$	S.D.	t-value	P-value
Position				**4.121**	**0.000**
Executive committees	47	176.5	23.5		
Operational officials	144	160.5	23.0		
Training experience					
QCC/CQI or TQM				**-1.708**	**0.090**
Never	172	163.5	24.3		
Ever	17	173.9	19.9		
ISO				**-0.99**	**0.347**
Never	140	163.4	25.0		
Ever	51	167.2	21.4		
QA				**-1.419**	**0.158**
Never	145	163.1	24.7		
Ever	46	168.8	21.6		
Five Ss activities				**-1.848**	**0.066**
Never	23	155.8	23.9		
Ever	168	165.6	23.9		
OD				**-2.320**	**0.021**
Never	16	151.2	23.8		
Ever	175	165.7	23.8		
ESB				**-0.443**	**0.655**
Never	140	164.0	23.7		
Ever	51	165.7	25.4		
Teamwork				**-1.990**	**0.048**
Never	62	159.5	26.1		
Ever	129	166.8	22.7		

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Table 10 indicates the differences in personnel's readiness for quality improvement, classified by the independent variables of no more than 2 groups by t-test. (continued)

Dependent variables	N	$\overline{X}$	S.D.	t-value	P-value
Hospital Accreditation				**-1.222**	**0.223**
Never	144	163.2	24.6		
Ever	47	168.2	22.4		
Self-Evaluation (Gen 9 items)				**-1.119**	**0.265**
Never	175	163.9	23.8		
Ever	16	170.9	26.5		

4.4.3 The investigation on the differences in personnel's readiness for quality improvement in the community hospitals, classified by the community hospitals by One-way ANOVA.

From the study, it is found that in the first community hospital, the personnel are the most ready for quality improvement ($\overline{X}$ = 173.6), followed by the third hospital ($\overline{X}$ = 163.1) and the second one ($\overline{X}$ = 157.8) respectively. Statistically, the different community hospitals also cause the different scores in personnel's readiness for quality improvement with the statistical significance at the 0.05 level (P = 0.001).

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Table 11 indicates the differences in personnel's readiness for quality improvement, classified by the community hospitals by One-way ANOVA

Community hospital	$\overline{X}$	S.D.	F-Ratio	P-value
1	173.6	23.7		
2	157.9	24.7		
3	163.1	19.9		
Total	164.5	24.1	**7.726**	**0.001**

4.4.4 The investigation on the differences in the characteristics of the organizational cultures, classified by the community hospitals by One-way ANOVA.

The results of the study reveal that the organizational cultures in the first community hospital support personnel's readiness the most ($\overline{X}$ = 32.5), followed by those of the third community hospital ($\overline{X}$ = 30.4) and the second community hospital ($\overline{X}$ = 29.4) respectively. According to the statistical analysis, the different community hospitals also cause the different organizational cultures that support personnel's readiness with the 0.05 level of statistical significance (P = 0.023).

Table 12 indicates the differences in the organizational cultures that support personnel's readiness in quality improvement, classified by the community hospitals by One-way ANOVA

Community hospital	$\overline{X}$	S.D.	F-Ratio	P-value
1	32.5	7.1		
2	29.4	6.2		
3	30.4	6.8		
Total	30.8	6.8	**3.848**	**0.023**

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4.5 Analytical results on the influences of the factors upon personnel's readiness for quality improvement in the community hospitals

The results from the multiple regression analysis on the influences of the factors upon personnel's readiness for quality improvement in the community hospitals by the stepwise method are indicated in Table 13.

The factor that influences personnel's readiness for quality improvement in the community hospitals with the statistical significance at the 0.05 level the most is the characteristics of the organizational cultures ($\beta = 0.433$, P-value = 0.000). It yields the positive effects upon personnel's readiness ($r = 0.479$). Moreover, its R^2 change is 0.487, and its regression co-efficient is 1.537. The second most important factor is the high level of informational perception in quality improvement ($\beta = 0.425$, P-value = 0.000). Its R^2 change is 0.78, and its regression co-efficient is 22.672. The third most important factor is the average level of informational perception in quality improvement ($\beta = 0.232$, P-value = 0.000). Its R^2 change is 0.044, and its co-efficient is 11.190.

The next most vital factor is the characteristics of the organizational leaders ($\beta = 0.176$, P-value = 0.002). It also has the positive effects upon personnel's readiness for quality improvement ($r = 0.004$). Its R^2 change is 0.015, and its co-efficient is 0.637. The educational level ($\beta = 0.134$, P-value = 0.005) is the next one, also positively influence personnel's readiness for quality improvement ($r = 0.206$). Its R^2 change is 0.018, and its co-efficient is 6.963. The married status ($\beta = 0.098$, P-value = 0.025) follows by when the R^2 change is 0.010, and its co-efficient is 4.715. The last most influencing factor is the types of personnel that are the professional or technical nurses ($\beta = 0.100$, P-value = 0.029). Its R^2 change is 0.009, and its co-efficient is 4.875.

All the factors mentioned above can explain the changes of the scores in personnel's readiness for quality improvement in the community hospital about 66.1 percent ($R^2 = 0.661$), and the constant value is 76.601. The equation of relationship is as follow.

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The score in personnel's readiness for quality improvement = 76.601 + 1.537 (the characteristics of organizational cultures) + 22.672 (the high level of informational perception on quality improvement) + 11.190 (the average level of informational perception on quality improvement) + 6.963 (the educational level) + 0.637 (the characteristics of organizational leaders) + 4.715 (the married status) + 4.875 (nurses).

Table 13 indicates the statistical results in the multiple regression analysis by the stepwise method of personnel's readiness for quality improvement in the community hospitals

Factors	b	β	r	R^2	R^2 change	Partial F
- Characteristics of organizational cultures	1.537	0.433	0.479	0.487	0.487	0.000
- High level of informational perception in quality improvement	22.672	0.425	0.418	0.565	0.078	0.000
- Average level of informational perception in quality improvement	11.190	0.232	0.273	0.609	0.044	0.000
- Educational level	6.963	0.134	0.206	0.627	0.018	0.005
- Characteristics of organizational leaders	0.637	0.176	0.224	0.642	0.015	0.002
- Marital status (Married)	4.715	0.098	0.165	0.652	0.010	0.025
- Types of personnel (Nurses)	4.875	0.100	0.161	0.661	0.009	0.029
Constant Value	76.601					
F = 50.880						
P-value = 0.000						

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4.6 Findings of the obstacles and problems in quality improvement of community hospitals

The studied population states that the first obstacle in the process of quality improvement in the community hospitals is that the officials have inadequately been trained (82.2%). Then, the problems are that the officials do not understand the methods and steps in quality activities, that there is no continuous quality improvement, that there is no participation from every level of officials, and that most officials do not understand quality improvement (81.2%, 73.8%, 72.3% and 66.5% respectively). Furthermore, 26.2 percent of the personnel think that communication within the organization is also the problem. (Table 14)

Table 14 indicates the numbers and percentage of the studied population's opinions towards the obstacles and problems in quality improvement of the community hospitals (N = 191).

Problems and Obstacles	Agree		Disagree	
	Number	Percentage	Numbers	Percentage
1. The officials have inadequately been trained.	157	82.2	34	17.8
2. The officials do not understand the methods and processes of quality activities.	155	81.2	36	18.8
3. There is no continuous quality improvement.	141	73.8	50	26.2
4. There is no participation from every level of officials.	138	72.3	53	27.7
5. Most officials do not understand quality improvement.	127	66.5	64	33.5
6. The doctors do not participate.	51	26.7	140	73.3

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Table 14 indicates the numbers and percentage of the studied population's opinions towards the obstacles and problems in quality improvement of the community hospitals (N = 191) (continued)

Problems and Obstacles	Agree		Disagree	
	Number	Percentage	Numbers	Percentage
7. There is not good communication within the organization.	50	26.2	141	73.8
8. The directors of the hospitals do not really support.	43	22.5	148	77.5
9. The leaders of the departments or sections do not really support.	40	20.9	151	79.1

The other problems and obstacles, summarized from the studied population's free opinions, are as follows.

1. Regarding personnel, the operational officials participate a little. They do not have a chance to state their opinions, nor do they have a chance to assign the visions and directions in quality improvement. Moreover, there is no co-operation and faith in the organization. Some officials discriminate themselves; they do not concentrate on the entire organization. Their opinions are not merged, and there is not acceptance in one another. There is no motivation in the conduction; there are no personnel who are trained and supposed to be the leaders of quality improvement. The operational officials do not comprehend quality improvement as they are only assigned to do something. Finally, some officials are used to the traditionally operational style. They do not concentrate on the patient-centered : moreover, they are afraid of changes. They do not really co-ordinate.

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2. Considering management and quality improvement conduction, there is no continuity in the process. There are insufficient public relations. The communication within the organization is not good enough. The operational officials do not perceive the information in quality improvement as much as they should. The conflicts among departments or sections are not solved. There is no participation from everybody. Besides, only some individuals are assigned to work on quality improvement. There is no continuous evaluation, so the process is just boomed for a short time. Some levels of personnel are not trained. Eventually, the organizational leaders focus on their ideas, so there is not a proper person to lead in the process.

3. About the policy, some hospitals do not have a clear policy direction in quality improvement.

Solving methods

1. The hospitals should have a vivid policy direction in quality improvement. Every level of officials should be thoroughly noticed, and the policy should be transferred into practice efficiently.

2. The organizational leaders must behave well to facilitate quality improvement. They must put an emphasis on and support quality improvement continuously. They must participate in the activities, accept the others' opinions, support everyone equally as well as evaluate the quality improvement process constantly.

3. Every level of officials must be sufficiently trained so that they can understand quality in the same way and put it into practice easily. They should be perceived in quality improvement continuously so that there would exist readiness and acceptance.

4. The operational officials must be provided a chance to express their opinions, to plan and to know the quality improvement process in order to stimulate them and bring about continuous quality improvement.

5. The officials must be provided morale. They should be rewarded if they work well. Moreover, emphasis must be put on the yields.

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6. There need more training programs in organizational development in order to build up faith and cooperation that are the bases in teamwork in the organization.

7. Time must be appropriate to every step in quality improvement, and the conductors really understand it.

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CHAPTER V
DISCUSSION

This study is aimed to investigate the level of personnel's readiness and the factors influencing personnel's readiness for quality improvement in the community hospitals as well as to study the problems and obstacles in the process of quality improvement in the community hospitals. The studied population is all governmental officials and officers genuinely functioning for the three community hospitals in Nakhonchaisi district, Nakhonpathom, namely Huayplu hospital, Luangporpern hospital and Nakhonchaisi hospital. It is a survey research employing a questionnaire as the instrument for collecting data from 191 samples. Then, the data were treated by the SPSS program. The statistics employed are the arithmetic means, percentage and standard deviation. Meanwhile, t-test, one-way analysis of variance and multiple regression analysis are employed to analyze the differences between the average scores of personnel's readiness, classified by the factors in order to study the forces influencing personnel's readiness. The results of the study can be summarized as follows.

5.1 Summary of the study

5.1.1 General characteristics of the studied population

Regarding the personal characteristics, it is found that the average age of the population is 32 years. However, there is 38.3 percent of the population that is between 25-32 years of age, that is the biggest group. In addition, there is 65.5 percent of population that is aged between 25-39 years. They are in the working age, and they have experienced work professionally; therefore, they are the essential manpower in changing and improving the quality of the community hospitals. The proportion of the married and that of the single are more or less equal; these are 48.2 and 45.5 percent respectively. Moreover, more than a half of the population (64.9 percent) received a Bachelor's degree, and there is 4.2 percent of the entire population who received a

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Master's degree. Most of the population (42.9 percent) earn between 7,500 and 12,000 baht a month. It is also found that there are about 76.91 percent of the population who earns between 7,500 and 19,000 baht monthly.

Considering the operational characteristics, it is shown that there are more operational officials (75.4 percent) than the executive committees. Most of them have worked between 5 and 10 years (35.1 percent). Meanwhile, those who have worked for less than 5 years and those of more than 15 years are more or less equal. There are 25.1 and 24.6 percent of them respectively. Additionally, the biggest group of population (59.2 percent) is the professional or technical nurses. Most population about 91.6 percent have undergone the organizational development training program (OD); meanwhile, there are 88 percent of them who have passed the Five Ss training one and 67.5 percent who have passed the teamwork program. More than a half of the population (52.4 percent) receives an average level of information; in the meantime, 28.2 percent of them state that they have receive a high level of information.

5.1.2 Characteristics of organizational leaders and organizational cultures

Regarding the studied population's opinions towards the characteristics of organizational leaders, it can be claimed that more than a half of the population (58.1 percent) thinks that their leaders have an average level of leadership for quality improvement in the community hospitals. Meanwhile, there are 23.6 percent of them who state that their leaders have a low level of leadership for quality improvement. If concluding the population who state their leaders have an average or a low level of leadership, 81.7 percent of the entire population are there.

Considering their attitudes towards the characteristics of organizational cultures, half of the population (64.9 percent) believes that their community hospitals have an average level in the characteristics that support quality improvement. Meanwhile, there are 12.6 percent of them who state that their community hospitals have a low level in the characteristics that support quality improvement. Finally, there are 77.5 percent of the studied population who express that their community hospitals have either an average or a low level in the characteristics that support quality improvement.

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5.1.3 Levels of personnel's readiness for quality improvement in the community hospitals

Referring to the criteria for classifying the levels of personnel's readiness for quality improvement in the community hospitals, most of the personnel, both the executive committees and the operational officials, are at the average level of readiness for quality improvement. The proportions are 53.2 and 63.2 percent respectively, so the executive committees are more ready than the operational officials. However, there are 81.2 percent of the entire population who are at an average or a low level of readiness. Regarding each particular aspect, both the executive committees and the operational officials are at a high level in attitudes towards quality improvement, but they are at a low level in participation in quality improvement in the community hospitals.

5.1.4 Results in the investigation on differences in personnel's readiness for quality improvement in the community hospitals, classified by each factor or independent variable

The study on differences in personnel's readiness for quality improvement in the community hospitals, classified by each aspect or independent variables, by t-test and one-way ANOVA with the statistical significance at the 0.05 level reveal the following results.

About personal factors e.g. marital status, educational level, income, the differences in these aspects result in the differences in personnel's readiness for quality improvement in the community hospitals with the statistical significance (P = 0.021, 0.000 and 0.001 respectively). The differences in ages are the only factor that cause the different levels of personnel's readiness without any statistical significance (P = 0.159). The samples who are married are more ready in quality improvement than those who are single. Those who receive a Bachelor's degree or higher are more ready in quality improvement than those who do not. Those who receive more than 19,500 baht a month are more ready in quality improvement than those who earn between 7,500 and 19,500 baht. However, the different ages do not affect personnel's readiness for quality improvement in the community hospitals.

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Considering the operational factors i.e. position, type of personnel, duration in professional operation and informational perception in quality improvement, the differences in these factors also cause the different levels of personnel's readiness in quality improvement in the community hospitals with the statistical significance (P = 0.000, 0.022, 0.009 and 0.000 respectively). The executive committees are more ready than the operational officials. The doctors, the dentists and the pharmacists are more ready than other personnel. The officials who have worked for more than 15 years are the most ready. In addition, the ones who perceive a high level of information are more ready than those who perceive an average or a low level of information.

Regarding the training experience, the officials who have undergone the organizational development program or the teamwork program are different in readiness from the one who have never done with the statistical significance (P = 0.021 and 0.048 respectively). The ones who have ever undergone these programs are more ready than the ones who have never done. However, the ones who have passed the training programs in QCC / CQI or TQM, ISO, QA, 5 Ss activities, ESB, HA, and the Gen 9 items are not different in personnel's readiness from the ones who have never passed them (P = 0.090,0.347 , 0.518, 0.066, 0.655, 0.223, 0.265 respectively).

Considering the opinions about the characteristical organizations i.e. the characteristics of the organizational leaders and those of the organizational cultures, the results are as follows.

It is found that the organizational leaders who have the different levels of leadership for quality improvement also cause the different levels of personnel's readiness for quality improvement in the community hospitals with the statistical significance (P = 0.000). The leaders who have a high level of leadership cause the higher level of readiness for quality improvement among their personnel than those who have an average level or a low level of leadership. (The average scores of personnel's readiness are 185.49, 164.06 and 149.20 respectively.)

In addition, the different organizational cultures result in the different levels of personnel's readiness with the statistical significance (P = 0.000). The hospitals with a high level of supporting organizational cultures tend to have the higher level of

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personnel's readiness than those ones with an average level or a low level of supporting organizational cultures. (The average scores of personnel's readiness are 190.33, 159.76 and 142.63 respectively.)

The results of this study also reveal that the organizational cultures of the first community hospital are more supportive to personnel's readiness than those of the third and the second ones ($\overline{X}$ = 32.55, 30.46 and 29.49 respectively). Moreover, the average scores in readiness for quality improvement of the personnel in the first hospital are higher than those ones in the third and the second hospitals ($\overline{X}$ = 173.60, 163.17 and 157.90 respectively).

5.1.5 The results of the analysis on the factors influencing personnel's readiness for quality improvement in the community hospitals

From the study on the influences of the factors upon personnel's readiness for quality improvement by multiple regression analysis, the most influencing factor is the characteristics of the organizational cultures. It is followed by the high level of informational perception in quality improvement, the average level of informational perception in quality improvement, the characteristics of the organizational leaders, the educational level, the married status, and the type of personnel (professional or technical nurses) respectively. All of these variables can explain about 66.1 percent of the changes in the scores on personnel's readiness for quality improvement in the community hospitals (R^2 = 0.661). Additionally, the characteristics of the organizational cultures (r = 0.479), the characteristics of the organizational leaders (r = 0.224) and the educational level (r = 0.206) positively influence personnel's readiness for quality improvement.

5.1.6 The problems and obstacles in quality improvement in the community hospitals

From this study, the problems and obstacles in quality improvement, according to the personnel's opinions are that the officials are not trained sufficiently, that they do not understand the methods or processes in quality improvement, that there is not continuity in the process, that there is no participation from every level of personnel, and that most personnel do not understand quality improvement. When the

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personnel express their opinions deliberately, it is found that the most problems derive from 3 major causes as follows.

1. The operational officials participate in the changes and improvement less. They do not have a chance to express their opinions. They are not trained sufficiently. They are not motivated to improve qualitatively. Some personnel are afraid of quality improvement, so there is not real participation in quality improvement in the community hospitals.

2. Regarding administration, there is no continuity in quality improvement. The communication within the organizations is not good enough. Transferring the quality policy to the operational officials is not effective. There is no continuous evaluation. Finally, there is not a good leader in quality improvement.

3. Some hospitals do not have an obvious quality improvement.

The suggestions from the studied population are as follows.

1. There must be a vivid quality improvement policy, and transferring the policy to the operational officials must be effective. The operational officials, moreover, should have a chance to state out their ideas and to perceive about the progress of quality improvement continuously.

2. The organizational leaders should act as a good example, participate in the activities, accept others' opinions and be neutral. They should support everybody or every department equally. Additionally, they should assess quality improvement seriously and progressively.

3. There must be adequate training programs for every level of officials continuously.

5.2 Discussion

From the findings of this study, the objectives of the study are achieved, as indicated in the following details.

5.2.1 It is now known that the personnel, both the executive committees and the operational officials, in the community hospitals in Nakhonchaisi district, Nakhonpathom, are at the average level of readiness. However, the executive

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committees are more ready than the operational officials. Regarding each aspect of personnel's readiness, both the executive committees and the operational officials are at the high level in attitudes towards quality improvement. It is a state of readiness among personnel, that can lead quality improvement in the community hospitals into a success.

5.2.2 It is shown that the factors influencing personnel's readiness for quality improvement in the community hospitals are the characteristics of organizational cultures, the information perception on quality improvement, the characteristics of organizational leaders, the educational level, the married status and the type of personnel. If these factors change, personnel's readiness for quality improvement in the community hospitals will be also changed.

5.2.3 The problems in quality improvement of the community hospitals are now known as follows. The officials are not sufficiently trained. There is no continuity in quality improvement. There is no participation from every level of personnel. Most officials do not really understand quality improvement. They are not motivated to improve qualitatively. There is not a good leader, and transferring the quality improvement policy to the operational officials is ineffective. These data can be used for planning and solving the problems to achieve the ultimate goal in quality improvement in the community hospitals later.

From the finding analysis, the details can be compared to the hypotheses as follows.

Hypothesis 1. The different personal factors such as age, marital status, educational level, income, etc. result in the different levels of personnel's readiness for quality improvement in the community hospitals.

Regarding age, it is found from the findings that the personnel who have different ages are not different in readiness. This does not coincide with the hypothesis. It is contrast to what Preeyaporn Wonganutrarot (1992:67) said that the persons with different ages would have different needs and attitudes. Moreover, it is opposite to what Somsak Santisuk (1985:29) said that the persons between 20 and 50 of ages are more ready to accept new things than those who are more than 50 years.

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Considering the groups of ages in this study, the personnel who are more than 39 years of age get a higher score in readiness than the other groups pretty obviously.

About the marital status, educational level and income, the personnel with the differences in these factors are different in readiness for quality development with the statistical significance. The ones who get married, hold a Bachelor's degree or higher, earn more than 19,500 baht a month receive a higher score in readiness than the other groups with the statistical significance. This is in accordance with the hypothesis, and it is also similar to the study of Siriwan Wachirawong (1993:abstract). She studied on the factors influencing readiness for operation in controlling and preventing hypertension of the public health officials in Supanburi and found that the educational level has a positive relationship to readiness for operation of the officials. Besides, the income is the most powerful factor that can predict the changes in readiness for operation the best.

The findings let us know that the personal factors i.e. the marital status, the educational level and the income influence personnel's readiness for quality improvement in the community hospitals. Consequently, these factors should also be considered when selecting the leading group for quality improvement in the community hospitals so that there will be the personnel who are ready to function in quality improvement to perform as the leaders, the trainers and the forcer for the changes and development in the quality of the community hospitals.

Hypothesis 2. The different factors about operational characteristics i.e. position, type of personnel, duration in professional operation, training experience and informational perception in quality improvement result in the different levels of personnel's readiness for quality improvement in the community hospitals.

Regarding the positions, the personnel with different positions are different in readiness for quality improvement in the community hospitals with the statistical significance. The executive committees tend to be more ready than the operational officials. This accords with the hypothesis and the ideas of Ferrans and Power (1985 cited in Chanakarn Boonnuch, 1997:24) that the positions mentally affect the officials. They cause stability and operation. The high position officials would feel that they are stable, so the positions would affect satisfaction and moral as well as operational

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behaviors that are beneficial to the organization. This means advantages to the organization in quality improvement also.

The different types of personnel also result in the different levels of personnel's readiness for quality improvement in the community hospitals with the statistical significance. This coincides with the hypothesis and the ideas of Rogers and Shoemaker (1971, cited in Tapthip Thitipongpanich, 1996:50) that the groups of persons would have the norm to assign the behaviors of the members in the groups. The norm derives from the beliefs and social values of the members. The different groups of people would, therefore, have the different norm, and this affects the different levels of admittance or refusal to the innovation. Quality improvement is the changes to innovation, so it results in the different levels of admittance or refusal from the different groups of people as well as the different levels of readiness for quality improvement.

The personnel with the different duration in professional operation also differentiate in readiness for quality improvement in the community hospitals with the statistical significance. It coincides with the hypothesis. Since duration in professional operation refers to the number of years that the officials have functioned in the current occupation, it results in the different professional skills and experiences, together with the attitudes and readiness in operation. Ernest (Ernest, et.al., 1971:523) also states that attitudes is the state of readiness derived from experiences. It makes a person decide to respond to the goal, the approach and the situation. Additionally, this finding is similar to the study of Anchalee Mulada (1998:abstract) who studied on the readiness in public health planning of the leaders and the officials responsible to public health planning in the public health offices in all the 75 provinces. She finds that duration in professional operation positively relates to readiness in public health planning.

Considering training experiences, it is found that the different training experiences between the officials who have undergone the organizational development training program and the teamwork program and those who have never result in the different levels of personnel's readiness for quality improvement in the community hospitals with the statistical significance. This is in accordance with the hypothesis; however, the different experiences in the training programs on QCI or TQM, ISO, QA,

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5 Ss activities, ESB, HA and the Gen 9 items, do not cause any differences in personnel's readiness for quality improvement. This does not coincide with the hypothesis.

It can be explained that there are about 91.6 percent of the personnel in the community hospitals who have undergone the training program in organizational development, so it causes an apparent difference between them and those who have never. It coincides with the ideas in preparation for hospital accreditation of Chatree Banchuen (1998:32-33) that the basic method employed in changing the attitudes and readiness of the personnel for quality improvement is the training program in organizational development. Its goals are that the personnel would love, co-operate, devote and be ready to serve the customers. Besides, it is the base for teamwork to build up a team with a power for changes. The training program in organizational development, accordingly, helps support the teamwork program which 67.5 percent of the personnel have undergone. Therefore, the two training programs positively affect personnel's readiness for quality improvement more obviously than the other training programs. These programs, moreover, cause the differences in readiness between those who have passed and those who have never with the statistical significance.

The different levels of informational perception in quality improvement also result in the different levels of readiness for quality improvement in the community hospitals with the statistical significance. This also accords with the hypothesis, and it is similar to the study on the factors affecting readiness in controlling and preventing hypertension of the public health officials in Supanburi by Siriwan Wachirawong (1993:abstract). It is found that informational perception in hypertension positively relates to readiness in operation of the public health officials.

Hypothesis 3. The factors about the different opinions on the characteristical organizations i.e. the characteristics of the organizational leaders and the characteristics of the organizational cultures result in the differences in personnel's readiness for quality improvement in the community hospitals.

It is found from the study that the characteristics of the organizational leader affect personnel's readiness. The leaders with different leadership result in personnel' readiness for quality improvement in the community hospital with the statistical

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significance. That is, the leaders with a high level of leadership cause a higher level of personnel's readiness than the ones with an average level or a low level of leadership. It is coincident with the hypothesis and the ideas of Worrapat Poocharoen (2000:29-30) and Anuwat Suppachutikul (1998:50) that the organizational leaders have an important role to make everybody in the organization dream and have the same goal as well as try to achieve that goal. The organizational leaders are the most essential to apply the quality improvement approaches into practice. They must comprehend, act as the example, support, motivate and stimulate their personnel to activate in the thorough activities. Moreover, it is also in accordance with the research on evaluating the 8 sampling hospitals under the Ministry of Public Health in the TQM project by Aongart Wiputsiri. It is found in the mentioned study that the different effort and continuity of the organizational leaders bring about the different progressive results in quality improvement of the community hospitals. These different results also reflect to the different levels of personnel's readiness in quality improvement.

In addition, the different organizational cultures also differentiate personnel's readiness for quality improvement in the community hospitals with the statistical significance. It also coincides with the hypothesis that the community hospitals that highly supports personnel's readiness would result in a higher level of personnel's readiness for quality improvement than the hospitals with an average level or a low level. Besides, it is also found that the first community hospital has the higher level of the organizational cultures than the third and the second community hospitals respectively. Then the first community hospital has the higher score on personnel's readiness than the third and the second community hospitals. This is a clearer evidence that coincides the hypothesis. Furthermore, the finding also accords with William (Williams, 1944 cited in Sujin Sawangsri, 1999:162), Thida Ningsanont (1999:2-3) and Anuwat Suppachutikul's ideas that quality is the results of forces by the organizational cultures that are social values and beliefs of the members in the organization. Quality improvement will be continuous and stable only if there are changes in the organizational cultures, and everyone in the organization must get the paradigm shift and the new operational philosophy. The leaders should not decide on every matter but build up leadership into every level of leaders. These leaders should work deliberately and have a chance to try on the new things. Finally, the problems

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must be focused on the system rather than an individual in order to create up co-operation in development and to solve the problems together. Every individual must participate so that he would be ready and the organization is progressively developed.

Hypothesis 4. The personal factors, the operational factors and the opinions towards the organizational leaders and the organizational cultures influence personnel's readiness for quality improvement in the community hospitals.

According to the study on the influences of the factors upon personnel's readiness for quality improvement in the community hospitals by the multiple regression analysis, it is found that the factor influencing personnel's readiness the most is the characteristics of the organizational cultures. Then the other factors followed are the high level of informational perception on quality improvement, the average level of informational perception on quality improvement, the characteristics of the organizational leaders, the educational level, the marital status and the type of personnel respectively.

The findings reveal that the organizational cultures positively affect personnel's readiness for quality improvement in the community hospitals ($r = 0.479$). It means the organizational cultures in the community hospitals that support personnel's readiness for quality improvement at a high level, an average level and a low level would directly result in the high level, the average level and the low level of personnel's readiness for quality improvement respectively. Furthermore, more than a half of the personnel in the hospitals (64.9 percent) think that the hospitals have the organizational cultures that support personnel's readiness at an average level. The average scores on each aspect are as follows: decentralization (1.8), solving problems on the system rather than finding the wrong persons (2.0) and putting importance on both the internal and the external customers (1.8). These scores are at the average level; therefore, more than a half of the personnel (61.8 percent) are at the average level in readiness with the average score of 164.5 accordingly. It can be said that the organizational cultures play a very crucial role on personnel's readiness for quality improvement in the community hospitals as they appoint people's beliefs and behaviors, on administration, decision making and behaving. (Paiboon Chanrian, 1989:12-13; Paisan Kraisit, 1992:17) The organization that focuses on

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commandments from the leaders or finding the wrong person do not stimulate creative thinking and trying on new things then. Moreover, there would not be co-operation in development and problem solving from everybody in the organization. The personnel lack readiness for quality improvement, as a result. Anthony (1998:65-66) states that the leaders must empower the other personnel so that the triangle of power would turn upside down and the executive committees and the operational officials can work with their full abilities in leadership. Thida Ningsanont (1999:2-3) and Anuwat Suppachutikul (2000:29-30) also claim that quality improvement would be continuous and stable only if there are changes in the organizational cultures. Everybody in the organization must have a paradigm shift, accept the quality cultures, treat quality as a part of work and make everyone in the organizational the internal customers for one another. They have to service one another in order to be ready to service the external customers. In sum, the characteristics of the organizational cultures essentially affect personnel's readiness for quality improvement in the community hospitals.

The high level and the average level of informational perception positively influence personnel's readiness for quality improvement in the community hospitals. The personnel who receive information highly or average would be more ready for quality improvement than the ones who receive information less. In other words, the more information the personnel receive, the more ready for quality improvement they are. Since quality improvement is changes in innovation, informational perception in quality improvement is a stimulant for the personnel to decide about the innovation and to decide whether they would participate in the quality improvement activities or not. These reflect personnel's readiness for quality improvement. The finding is similar to Siriwan Wachirawong's study (1993:abstract) that informational perception on hypertension positively relates to operational readiness of the public health officials. It is also the third best factor to predict the changes in readiness.

The characteristics of the organizational leaders also positively influence personnel's readiness for quality improvement in the community hospitals. The leaders with a high level, an average level and a low level of leadership for quality improvement would result in a high level, an average level and a low level of personnel's readiness accordingly. More than a half of the personnel in the community hospitals (58.1 percent) think that their leaders are at an average level of leadership;

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therefore, more than a half of them (61.8 percent) are at an average level of readiness also. This accords with the ideas of Danai Tienput (2000:191-193), Ross and Hendry (1958:102-113) and Anuwat Suppachutikul (1999:29) that the organizational leaders are the most important to convey the approaches and the goal of quality improvement to all personnel so that they would understand and can do as the leaders do. Being a leader, consequently, means both leading and managing. What the leaders do would be the images of themselves as well as of the organizations. The personnel would imitate and behave as well. If the leaders lack leadership or do not seriously show out the roles in supporting quality improvement, there would be no synergy from every level of personnel in the hospitals. In this case, the leaders themselves are the obstacles to the changes and quality improvement.

The educational level positively relates to personnel's readiness for quality improvement in the community hospitals. The personnel with high education are more ready for quality improvement than those with lower education. The finding indicates that the personnel with a Bachelor's degree or higher are more ready than those who have lower education. This coincides with Siriwan Wanchirawong's study that the highest educational level positively relates to operational readiness of the public health officials.

The marital status (X_2) influences personnel's readiness for quality improvement in the community hospitals. The personnel who are married are more ready for quality improvement than those who are single, divorced or separated. This is similar to the study of Somporn Ittideshpong that the marital status positively relates to operation of the directors of the community hospitals. The directors who are married receive a higher score in operation than the single ones.

The type of personnel (X_2) affects personnel's readiness for quality improvement in the community hospitals. The professional or technical nurses are more ready for quality improvement than the other types of personnel. It is in accordance with the study of Chartree Banchuen (1998:36) that the first and high department in quality improvement is the nursing department. This reflects that the professional and technical nurses are more ready for quality improvement than the other types of personnel.

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CHAPTER VI
SUMMARY AND SUGGESTIONS

6.1 Summary

This study is aimed to investigate the level of personnel's readiness and to study the factors influencing personnel's readiness for quality improvement in the community hospitals as well as the problems and obstacles in quality improvement of the community hospitals in Nakhonchaisi district, Nakhonpathom. It is found that both the executive committees and the operational officials are at an average level of readiness. However, the executive committees are more ready than the operational officials. Regarding each aspect, the personnel of the community hospitals are at a high level in the good attitudes towards quality improvement. It is the state of readiness of the personnel that can bring about succeed in quality improvement if every level of personnel participates in the activities, especially that the operational officials have a chance to express out their opinions and to set the policy, visions and missions. Moreover, the process and the method in transferring the quality policy into practice would make the personnel accept the changes and know their roles. These can lead to good co-operation in quality improvement.

According to the analysis on the factors influencing personnel's readiness, the first three essential factors are the characteristics of the organizational cultures, informational perception in quality improvement and the characteristics of the organizational leaders. These factors positively affect personnel's readiness for quality improvement. If the organizational cultures in the community hospitals highly support personnel's readiness, or if the personnel perceive information about quality improvement at a high level, or if the organizational leaders have a high level of leadership, the personnel would be at a high level of readiness. The findings indicate that the crucial problems and obstacles in quality improvement are that the personnel

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are not sufficiently trained, that there is no continuity in quality improvement, that there is no participation from every level of personnel, and that most officials do not really understand quality improvement. Moreover, there is not a good leader. There is no motivation in quality improvement, and transferring the quality improvement policy to the operational officials is not effective enough.

6.2 Suggestions

It is found from the study that the main factors affecting personnel's readiness for quality improvement in the community hospitals are the characteristics of the organizational cultures, informational perception and the characteristics of the organizational leaders. Therefore, the following suggestions concern mostly with these three aspects.

6.2.1 According to the findings about the characteristics of the organizational cultures, decentralization, solving problems at the system and servicing the customers are the most positively influencing personnel's readiness for quality improvement in the community hospitals. Consequently, the first thing to be conducted in the organizations is to change the organizational cultures by decentralizing, solving the problems by everybody and putting importance on both internal and external customers. These methods are instances.

1. Re-appoint the visions, the missions and the values of the organization by everyone to be the sense of direction of the organization and to stimulate the quality improvement trend. Moreover, it is to set up the goal all together.

2. Create up the operational system by group process or teamwork. The hospitals should set up the teams within the department, between the departments and between the professions, and the executive committees must provide the full authority to the team by decentralizing the decision making power to the junior committees and teams. The team must be able to design the job and the new system. The decision on changing the system or operation process depends on the consensus of the teams, and every person or every department must be responsible to solve the problems together in order to adjust the operational system to facilitate work qualitatively. The executive

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committees would act as a consultant if asked and evaluate the output and the impact from work, both positive and negative.

3. Build up the open evaluation system by making the evaluation system both in the organizational and the individual levels. There must be an indicator to assess the success of the organization that can response people's needs (service quality). The individual's success is assessed from servicing both internal and external customers (service mind). The evaluation system must reflect the output of the performances of the personnel or the teams in order to support participation, teamwork and good relationship with the customers.

4. There must be a competition within the organization by offering a chance to present the outputs every six months and rewarding the successful departments or teams in order to motivate operation and build up co-ordination to the teams.

6.2.2 It is found that informational perception in quality improvement positively affect personnel's readiness for quality improvement in the community hospitals. The personnel who perceive a high level of quality improvement would be the most ready. Therefore, there should be some processes as follows.

1. There must be public relations to every level of personnel by means of every way in communication such as a meeting on quality policy from every level of executive committees, the monthly meeting of the hospitals or of the departments, the notice boards, etc. effectively. This is to build up comprehension in quality improvement and in the directions of quality improvement as well as the progress in quality improvement of the hospital. Upward communication from the operational officials must be efficient so that they can state their opinions and participate. Admittance on changes of every level of personnel is also vital to build up good co-ordination for quality improvement.

2. Some personnel should be appointed responsible to public relations in order to publicize the matters about quality improvement efficiently and thoroughly.

3. Every level of personnel should be trained continuously and adequately in order to increase their knowledge, skills and experiences necessary to quality improvement. Furthermore, there should be a study on training need as for planning

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the training programs. The executive committees must emphasize on training every level of personnel and consider training an investment, not a cost.

6.2.3 According to the results of the study, the characteristics of the organizational leaders positively influence personnel's readiness for quality improvement. The personnel think that the organizational leaders with a high level of leadership would be the most ready for quality improvement. Therefore, the characteristics of the organizational leaders should facilitate improvement. They must be a good example, put an emphasis and support quality improvement seriously and continuously. Moreover, they must declare the quality improvement policy vividly as well as convey their approaches and the quality improvement targets to everybody in the organization. They must participate in the activities, accept others' opinions and provide a chance for the operational officials to participate in administration. Furthermore, they must act neutrally and support everybody or every department equally. Finally, they must evaluate the results of the quality improvement progressively by organizing a meeting to elicit the problems and progress in quality improvement of each department or team every month.

6.3 Suggestions for further studies

1. According to the study, the characteristics of the organizational cultures influence personnel's readiness for quality improvement the most. Consequently, there should be a qualitative research on the characteristics of the organizational cultures that support personnel's readiness for quality improvement in the community hospitals in order that the results can be a way to change the organizational cultures appropriately for quality improvement. Moreover, it can be an instrument to analyze the organizational cultures and to diagnose ones that obstruct quality improvement or ones that help the organizations achieve the goal in quality improvement.

2. As there has never been any previous studies on personnel's readiness for quality improvement in the community hospitals, there should be studies on this topic in other areas in order to compare the findings to this study.

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3. There should be a comparative study on the outcomes between the community hospitals in which the personnel are ready for quality improvement and the ones in which the personnel are not ready or are ready at a low level for quality improvement in order to find out whether there are differences.

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APPENDIX

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Questionnaire No. .....

Questionnaire

For the research on Personnel's Readiness for Quality Improvement in the Community Hospitals in Nakhonchaisi, Nakhonpathom

Direction This questionnaire is constructed in order to elicit the information about each aspect in quality improvement of the community hospitals. The gathered information would be utilized in improving the mistakes in quality improvement in order to achieve the ultimate goal.

Therefore, please answer these questions directly, according to your perception. Your information would definitely be secret and it would never affect your work at all. The name of your hospital, moreover, is not indicated in the analysis and discussion of this research.

This questionnaire is separated into 4 parts as follows.

1. General data of the questionnaire
2. Information about the organizational leaders and the organizational cultures of the questionee's hospital
3. Information about personnel's readiness for quality improvement in the questionee's hospital
4. Problems, obstacles and suggestions in quality improvement of the questionee's hospital

Thank you very much
for your well cooperation
Pannipa Chuenklinthoop
Researcher

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Part I. General Information

This part is about general information such as age, educational level, marital status, income, position, type of personnel, duration of professional operation, training experience and perception in quality improvement information.

Please answer these questions about yourself by filling in the gaps or ticking (/) in the blanks in front of the statements that are the closet to yourself.

1. Age ..... years
2. At present, you work in the department/ section of
   .....
3. Your highest educational level
   ☐ 1. Lower than certificate ☐ 2. Certificate
   ☐ 3. Bachelor degree or equivalent ☐ 4. Master degree or equivalent
   ☐ 5. Other (please specify) .....
4. Marital status
   ☐ 1. Single ☐ 2. Married
   ☐ 3. Divorced/ separated
5. Your monthly income including salary, overtime allowance and other income from the hospital is ..... baht.
6. At present, you work as a/ an
   ☐ 1. Doctor/ Dentist ☐ 2. Professional/ technical nurse
   ☐ 3. Pharmacist ☐ 4. Academy
   ☐ 5. Public health official ☐ 6. Other (please specify)
   .....
7. Your duration of professional operation
   ☐ 1. Less than 5 years ☐ 2. 5 -10 years
   ☐ 3. 11 - 15 years ☐ 4. More than 15 years
8. At present, your position is a/ an
   ☐ 1. Leader of a particular field ☐ 2. Section leader
   ☐ 2. Head of the department ☐ 4. Official

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9. Have you ever undergone these following training programs?

9.1 CQI or TQM or QCC	☐ yes	☐ no
9.2 ISO	☐ yes	☐ no
9.3 QA	☐ yes	☐ no
9.4 5 Ss activities	☐ yes	☐ no
9.5 OD	☐ yes	☐ no
9.6 ESB	☐ yes	☐ no
9.7 teamwork activities	☐ yes	☐ no
9.8 HA	☐ yes	☐ no
9.9 9 items of GEN	☐ yes	☐ no

10. From which sources have you learnt about the approaches and the goal of the quality improvement of the hospitals? (You may have more than one answer.)

☐ 1. A meeting on quality policy by the senior executive committees

☐ 2. A meeting of the executive committees of the hospital

☐ 3. A monthly meeting of the hospital

☐ 4. A meeting of the department or section

☐ 5. A meeting of the quality improvement committees

☐ 6. Notice boards

☐ 7. Others (please specify)

.....

11. Frequency of the perception of the quality improvement information (per month)

☐ 1. Low (less than once a month or never)

☐ 2. Average (about once or twice a month)

☐ 3. High (more than twice a month)

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Part II. Characteristics of organizational leaders and cultures

2.1 Characteristics of the organizational leaders or the director of the hospital

Direction: Please read the following statements and consider your organizational leader's characteristics. Then, tick (/) into the blanks on your right hand, that are the closest to the real condition or your opinion.

Statements	High	Average	Low
1. How much does the director of your hospital provide a chance for the officials to participate in the changes and planning in the quality improvement of the hospitals?			
2. How much does the director of your hospital empower the officials by training, providing knowledge or giving them the power to decide to solve the problems?			
3. How much does the director of your hospital support the officials in terms of morale so that they would trust in the director?			
⋮ 20.			

2.2 Characteristics of organizational cultures

Direction: Please read the following statements and consider your organizational leader, your colleagues and your operational behaviors. Then, tick (/) into the blanks on your right hand, that are the closest to the real condition or your opinion.

Statement	High	Average	Low
A. Decision making			
1. How much have you got a chance to express your opinions or new approaches for solving the problems or improving work of your hospital?			

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Statement	High	Average	Low
2. How much have you got a chance to try out new methods for enlarging your hospital's efficiency?			
3. How much can you decide to solve the problems or improve the quality system in your hospital? ⋮ 5.			

B. Problem solving			
6. How much has every department or section in your hospital participated or decided together to improve the operational system to enhance the efficiency?			
7. How much has your department or section improved some systems to response other department or sections?			
8. How much has your department or section solved the problems systematically so that they would not occur again? ⋮ 11.			

C. Servicing the customers			
12. How much have all personnel in your hospital serve one another?			
13. How much can you state out your desires to other sections in the hospital conveniently?			
14. How much have your colleagues in other sections understood and responded your desires? ⋮ 15.			

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Part III. Each aspect of personnel's readiness for quality improvement in the hospitals (Personnel reveal only to government officials, excluding employees.)

Direction: Please read the following statements and consider yourself, your colleagues and your executive committees, referring to doctors, leader of department, leader of the sections about readiness for quality improvement. Then, tick (/) into the blanks on your right hand, that are the closest to the real condition or your opinion.

Statement	High	Average	Low
A. Comprehension			
1. How much do you understand about quality improvement, direction and goal of the hospital?			
2. Do you think quality reveals only to working for the professional standard?			
3. Do you understand that quality is to response the necessary needs of the customers and patients for their satisfaction on the professional standard basis?			
7.			
B. Attitudes			
8. Do you feel that quality improvement brings about better changes?			
9. How much do you believe that your department's current problems can be improved?			
10. Do you believe that you can learn new things?			
12.			

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C. Awareness			
Statement	High	Average	Low
13. Do you think that quality improvement is the responsibility of the executive committees, and you are just a fellow?			
14. If you do your job slowly, how much would it affect the hospital's survival? 18.			
D. Support from the executive committees (Doctor, the leader of the department or section)			
19. How much do the committees play a role in guiding or supporting the officials to standardize or improve the operational methods of the department? 20. How much can the committees be able to motivate or stimulate the officials to cooperate and accept the changes?			
21. How much do the executive committees improve the managerial system, rearrange the working environment in order to create good atmosphere in quality improvement? 25.			
Participation			
26. For your hospital, the executive committees appoint the vision, goal and strategies in quality improvement.			
27. How much do you participate in assigning the visions, mission and goal in quality improvement of the hospital?			

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Statement	High	Average	Low
28. How much do you apply the visions and mission into implementation for improving your department? 31.			
Cooperation			
32. You receive well cooperation from other departments in solving and improving the operational system.			
33. You are willing to cooperate with other departments in the hospital to solve the problems together.			
34. You are ready to exchange the information both individually and professionally in order to trade the ideas to solve the problems. 36.			
Teamwork			
37. All officials in your department trust one another.			
38. All officials in the hospital work with good attitudes to one another.			
39. When there occurs a problem either among departments or professions, brainstorming is utilized to solve the problem. 43.			
Patient-centered Operation			
44. In your hospital, customers and patients' satisfaction is the operational indicator.			
45. There is a continuous improvement in operation on the basis of experiences as well as evaluation from the patients, colleagues and dealers of the hospitals.			

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Statement	High	Average	Low
46. How much do you learn about feeling and opinion and function as the patients and customers want?			
49.			

Part IV. Problems and obstacles

Direction. In changing and improving your hospital's quality to achieve the goal of hospital accreditation, what are the problems and obstacles in your opinion? Please tick (/) in the blanks on your right hand, that are the closet to your opinion. Moreover, please suggest some methods to solve the problems.

1. The problems and obstacles in improving your hospital's quality are

	Agree	Disagree
Most officials do not understand quality improvement.		
The officials do not understand the methods and steps in quality activities.		
The officials have insufficient training experience.		
There lacks participation from all levels of officials.		
There is not a continuous quality improvement.		
The director of the hospital does not really support.		
The doctors do not participate.		
The leaders of the department or section do not really support.		

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Other problems and obstacles are

.....

.....

.....

.....

.....

.....

2. In your opinion, the ways to solve these problems are as follows.

.....

.....

.....

.....

.....

.....

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BIOGRAPHY

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NAME	Mrs. Punnipa Chuenklintoop
DATE OF BIRTH	7 November 1958
PLACE OF BIRTH	Nakhonratchasima Province, Thailand
INSTITUTION ATTENED	Boromratchonni Nakhonratchasima Nursing College, 1977-1981 : Diploma in Nursing and Midwifery Equivalent to Bachelor of Nursing Mahidol University ,1999-2001 : Master of Arts (Public Administration)
POSITION & OFFICE	1989 – Present Nakhonchaisi Community Hospital, Ministry of Public Health. Position : Professional Nurse ,Level 7

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