Care-giving and Care-seeking Behaviours of Parents Who Take Their Children to an Emergency Department for Non-urgent Care

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ABSTRACT

Objective: This study explored the care-giving and care-seeking behaviours of parents who took their children to the emergency department (ED) of a large urban hospital in Western Canada for non-urgent care.

Method: Data were collected from a convenience sample of 114 parents during a two-week period in January 1992, using a self-administered 53-item questionnaire. The data were analyzed using nonparametric statistics (Chi-square) and thematic content analysis.

Results: Eighty-two percent of parents were unsure of or overestimated the seriousness of their child's illness or injury. Prior to attending the ED, 40% of parents administered comfort measures and 45% gave medications. Only 17% of parents used at-home reading materials, while 31% sought lay advice. Fifty-eight percent of parents did not try to contact their family physician or the ED by telephone before coming to the ED. Forty-eight percent of parents who phoned their family physician were unable to obtain advice, and those who did were almost always referred to the ED. Eighty-eight percent of those who phoned the ED were instructed to bring the child to the ED.

Interpretation: The results suggest the need for more acceptable, accessible community primary care services.

In Canada, as in most other western countries, the last 40 years have produced marked changes in how often and for what purpose hospital emergency departments (EDs) are used.¹ Demand for ED services has increased more rapidly than for any other ambulatory health care service. A large part of this increase is attributed to individuals seeking non-urgent care (treatment for an illness or injury not requiring the resources of the ED).² In a review of Canadian studies of non-urgent ED use, non-urgent visits accounted for from 3% to 77% of ED visits.³

The use of EDs for non-urgent care raises several important issues. When compared to care provided in a community-based alternative such as a physician's office, non-urgent ED care has been shown to be hurried, fragmented, and of lower quality.¹ Non-urgent ED care is also more costly than comparable community-based care, and results in greater use of laboratory tests and x-rays.^{4,5} Moreover, ED non-urgent use can contribute to overcrowding and long wait periods, thereby decreasing the quality of care received by patients requiring more urgent care.⁶

Non-urgent pediatric ED use is of particular concern, as children are more frequent consumers of ED services, particularly for non-urgent care,⁷ and can account for almost half of all ED visits.⁸ There is little Canadian research that explores non-urgent pediatric ED use and the research that has been done was conducted in the 1960s and 70s. No Canadian studies were found that focused on the care-giving and care-seeking behaviours preceding non-urgent pediatric ED use. Understanding why parents bring their children to the ED for non-urgent care is an integral part of planning, delivering, and funding pediatric health care service.⁹

The research question addressed in this study was: What care-giving and care-seeking behaviours preceded parents' decisions to take their children to the ED for non-urgent care?

METHOD

The site for the study was one hospital in a large Western Canadian city. Non-urgent care was operationalized using the Emergency Workload Measurement System (EWMS).¹⁰ The EWMS was developed by Alberta Health in the early 1990s,

The translation of the Abstract appears at the end of the article.

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and at the time of the study was being used throughout Alberta. The EWMS uses the ED discharge diagnosis to assign ED visits to one of five incremental levels, based on the average amount of expected nursing care time (Table I). An EWMS score of 1 or 2 is "comparable in urgency to a walk-in or office-based physician visit."¹⁰ For the purposes of this study, "non-urgent care" was defined as an ED visit assigned an EWMS score of 1 or 2. A child was defined as anyone less than 16 years of age.

A two-step sample selection process was used. Step one involved exclusion of any child who arrived at the ED by ambulance, or who was deemed by the admission clerk to require immediate assessment and treatment. All other parents with children were given a numbered envelope containing an information letter and the questionnaire. A total of 331 parents received envelopes during the two-week data collection period in January 1992. Sixty percent (n=199) of parents returned completed questionnaires. Most questionnaires were completed in the waiting room before the child was seen by a health professional.

Step two of the selection process involved pairing each of the completed questionnaires with the child's ED chart. Included in the sample were all children receiving an EWMS score of 1 or 2. Excluded were those receiving an EWMS score of 3, 4 or 5 or those who were admitted to the hospital. A total of 114 (63.3%) of the 180 paired questionnaires were retained for the study.

The 53-item questionnaire contained both fixed response (primarily at the nominal and ordinal level) and open-ended questions. It was designed to collect information about the nature, seriousness, and duration of the child's symptoms; the parent's at-home treatment of these symptoms; their use of reading material and/or lay advice; and their attempts to obtain and use professional advice before coming to the ED. Information was also elicited about the child's overall health, past ED use, whether the child had experienced similar symptoms in the past and the treatment received at that time, and a variety of socio-demographic family information. The questionnaire, which was designed by the first author, was reviewed for content validity by four ED nurses and piloted with three parents who had recently taken

TABLE I**Emergency Workload Measurement System (EWMS) Scale**

EWMS Score	Average Nursing Time	Patient Classification	Examples of Discharge Diagnosis
1	25 minutes	Minimum	Common cold, rashes, feeding problem, minor childhood diseases, sprain, strain, allergic reaction (stable), diarrhea and/or vomiting
2	38 minutes	Moderate	Upper respiratory infection with fever, lacerations, neck pain
3	75 minutes	Complex	Asthma without acute respiratory failure, bronchopneumonia, croup, fractures, seizure, appendicitis
4	130 minutes	Extensive	Asthma with acute respiratory failure, meningitis, burns
5	150 minutes	Critical	Cardiac arrest, respiratory arrest, drowning

Source: *Alberta Emergency Services Sub-committee Report 1992*, p. 11. Alberta Health and Wellness, Edmonton, AB.

TABLE II**Socio-demographic Characteristics of Parents (n=114)**

Marital Status of Parents	n (%)	
Married	92 (81%)	
Common law	9 (8%)	
Separated/Divorced	8 (7%)	
Never married	5 (4%)	
Age of Parents (years)	Mother n (%)	Father n (%)
<25	15 (13%)	7 (7%)
26-35	61 (54%)	49 (49%)
36-50	37 (33%)	45 (45%)
Missing	1 (1%)	13 (11%)
Education of Parents	Mother n (%)	Father n (%)
Less than High School	8 (7%)	5 (4%)
High School	53 (47%)	43 (38%)
College	32 (28%)	28 (25%)
University	20 (18%)	25 (22%)
Missing	1 (1%)	13 (11%)
Age of Children (years)	n (%)	
<1	15 (13%)	
1-4	33 (29%)	
5-9	39 (34%)	
10-15	27 (24%)	
Number of Children in Family	n (%)	
1	38 (33%)	
2	56 (49%)	
3	14 (12%)	
4+	6 (5%)	
Location of Family Residence	n (%)	
Immediate community	70 (61%)	
Other area of the city	21 (18%)	
Satellite community	14 (12%)	
Elsewhere	9 (8%)	
Family Income	n (%)	
< \$20,000	16 (14%)	
\$20,000 to \$39,999	33 (29%)	
\$40,000 to \$59,999	27 (24%)	
\$60,000 to \$80,000	20 (18%)	
> \$80,000	9 (8%)	
Missing	9 (8%)	

their child to an ED for non-urgent care. The questionnaire took approximately 20 minutes to complete. (A copy of the questionnaire is available from the first author).

Data from the questionnaire and ED chart (EWMS score and discharge diagnosis) were entered into a computer file and

analyzed using descriptive and nonparametric statistics (Chi-square). Relationships between parental care-giving and care-seeking behaviours and family attributes (e.g., age, education) were identified. Thematic content analysis was used to analyze the responses from the open-ended questions.

TABLE III

Parents' Rating of the Seriousness of Their Child's Symptoms by Type of Symptom

Seriousness Rating	n*(%)	Type of Symptom
Very serious	7(7%)	Fever, rashes, injuries to the extremities, nausea, vomiting and/or diarrhea.
Serious	29(27%)	Injuries to the extremities, fever, earaches, sore throats, abdominal pain, stiff necks, headaches, rashes, asthma, achy joints, eye injury, cuts, dog bite, nausea, vomiting and diarrhea.
Not serious	19(18%)	Cuts, falls, broken teeth, asthma, coughing, colds, fever, earaches, sore throats, rashes, nausea, vomiting and diarrhea.
Unsure	53(49%)	Falls, injuries to the extremities, cuts, fever, rashes, colic, abdominal pain, ear aches, sore throats, coughing, colds, stiff neck, headache, nausea, vomiting and diarrhea.

* Percent of parents not asked to return to the ED by physician (n=108)

TABLE IV

Parents' At-home Care-giving and Information-seeking Behaviours

Behaviour	n*	(%)
Comfort Measures	43 †	(39.8%)
Rest	19	
Sponging	12	
Diet changes	11	
Ice application	11	
Steam (vaporizer)	9	
Wound care	7	
Others	9	
Medications	49 ‡	(45.4%)
Antipyretics	36	
Expectorants/Antitussives	9	
Antihistamines	5	
Other	5	
Use of Reading Materials	18	(16.7%)
Lay Advice	33	(31%)
Relatives	21	
Friends	8	
Other	4	

* Total n=108 (those parents not asked to return to the ED by an ED physician)

† Some parents used more than one comfort measure

‡ Some parents gave more than one medication

RESULTS

The sample represented a broad cross-section of families (Table II). Forty percent of the parents resided outside of the community in which the ED is situated. Parents ranged in age from 19-50 years, and 80% were married. Most were educated beyond high school, and almost 90% of the fathers and 50% of the mothers were employed full-time. Almost half had family incomes between \$20,000 and \$60,000. Just over 40% of the children brought to the ED were under the age of 5 years. All but 10 (9%) of the families had a family physician or pediatrician.

Children arrived at the ED with a range of symptoms. Two thirds (67%) presented with

fever (n=32); coughing (n=15); arm or leg pain (n=15); or nausea, vomiting and/or diarrhea (n=14). The remaining third (33%) arrived with a range of other symptoms, including headache, earache, sore throat, sore neck, congestion, rash, bruise, cut, and/or falls. Most (81%) of the parents took their children to the ED within 24 hours of becoming aware of their child's symptoms. In 43% of cases (n=46), the mother was the first person to recognize the child's symptoms. School-age children (5 years of age and older) were more likely to recognize symptoms themselves and then alert their parent (Chi square 54.96, df=4, significance $p<0.001$).

Table III reports the parents' ratings of the seriousness of their child's symptoms. About half (n=53, 49%) of the parents were unsure of the seriousness of their child's symptoms; 27% (n=29) rated them serious; 18% (n=19) not serious; and 6% (n=7) very serious. Some symptoms (e.g., fever, rashes, nausea, vomiting, and diarrhea) appeared in all four seriousness categories. No significant relationship was found between the parents' seriousness rating and past experience with the same or a similar illness or injury, or between the seriousness rating and the time between symptom awareness and arrival at the ED.

Parents used a variety of care-giving measures before taking their children to the ED (Table IV). About 40% reported the use of one or more comfort measures, with the most common measures being bedrest and sponging. Almost half of the parents administered medication, with Tylenol by far the most common medication given. Infants and preschoolers tended to receive more comfort measures and medications than did school-age children

(Chi-square 6.65, df = 2, $p=0.036$). Children who had a similar illness or injury in the past received more comfort measures and medications than children who did not have a similar illness or injury in the past (Chi-square 10.72, df = 2, $p=0.005$). Even though 62% (n=67) of parents reported that they had reading material about childhood illness and injury, few parents used this material before coming to the ED. There was no relationship between use of reading material and the parent's age, parent's education, number of children in the family, parent's seriousness rating, or the child having had a similar illness or injury in the past. About one third of parents sought lay advice about their children's symptoms, most frequently from relatives. Younger parents (less than 25 years of age) were more likely to seek lay advice than older parents (Chi-square 6.56, df = 2, $p=0.034$). In 56% of cases where advice was provided, the parent was advised to take their child to the ED.

The professional care-seeking behaviours of the parents are presented in Figure 1. Six of the 114 parents in the sample were asked to return to the ED by an ED physician. Of the remaining 108 parents, 91% (n=98) indicated that they had a family physician/pediatrician for their child. Fifty-eight percent (n=57) of these parents were classified as "ED self-referrals", i.e., they arrived at the ED without first trying to contact their child's physician or the ED by telephone. The remaining 41% (n=40) were classified as "professional ED referrals", i.e., they arrived at the ED after telephoning their physician's office (n=23), the ED (n=13) or both (n=4). Of those parents who phoned their family physician (n=27), almost half (n=13) were unable to make telephone contact, and of those who were able to speak directly to the physician (n=12), almost all (n=10) were referred to the ED. Similarly, of those 17 parents who phoned the ED, 15 were advised to bring the child to the ED. All of the parents without a family physician (n=10) were classified as ED self-referrals, i.e., none of these parents phoned the ED.

Forty-nine (43%) of the 114 parents in the sample indicated that they had considered taking their child elsewhere before coming to the ED. The most frequently mentioned alternatives were walk-in clinics

Figure 1. Professional care-seeking behaviours leading to use of the emergency department for non-urgent pediatric care

(55%) and physicians' offices (43%). No significant difference was found between consideration of a community alternative and number of children, the child having the same or a similar illness or injury in the past, or the parent's use of reading material.

Information on factors that influenced the parents' decision to use this ED was elicited via two open-ended questions. Seventy-five (66%) of the parents responded to these questions. Thematic content analysis revealed six major categories of factors that seemed to play a part in their

decision-making (Table V). The most common reasons identified were perceived seriousness of symptoms, closely followed by physician availability (unable to contact physician by telephone, office closed, unable to make an appointment "quickly"). Convenience and the perception that the ED provides better care than community alternatives were also frequently cited. Past ED use was infrequently mentioned. Many of the comments suggested that more than one factor was influential in parents' decisions to use the ED.

DISCUSSION

This study suggests that for these patients, the ED functioned as an adjunct for the provision of convenient after-hours treatment of a range of common pediatric illnesses and injuries. Two thirds of parents attempted at-home treatment in the form of comfort measures or medication; however, their need for reassurance may have led to ED use. Others have noted that parental reassurance visits can account for about one third of health care visits involving children.¹¹ A large

TABLE V
Parents' Reasons for Using the ED for Child's Illness/Injury

Reason	n* (%)	Exemplar Quotations
Seriousness of Symptom	24/75 (32%)	<p>"My husband had a tumor when he was young and had severe headaches. I wanted to be safe not sorry." [from the mother of a 9 year old who had been complaining of a headache].</p> <p>"I was concerned about internal injuries. He may have injured his kidney or fractured his hip. [My child was in] serious pain." [from the mother of an 8 year old who pulled a muscle while playing hockey.]</p>
Physician Unavailability	21/75 (28%)	<p>"My pediatrician's office was closed for the day. I can come here when the office is closed in the evening and on the weekend." [from the mother of a 7 month old brought to the ED at 18:30 hrs and diagnosed with otitis media].</p> <p>"I would rather have taken her to her doctor, however, he doesn't work nights and I would have to take three hours off work."</p>
Convenience	15/75 (20%)	<p>"The hospital is nice and close and has always been good to us."</p> <p>"[The ED is] close and easy to get to."</p>
ED Provides Better Services	15/75 (20%)	<p>"With children we believe utmost care must be taken to ensure that they are receiving proper, qualified professional help in a facility that is complete with modern equipment and well trained support staff." [from the mother of a 14 year old who was brought to the ED with a foot injury.]</p> <p>"[We came to the ED] to ensure [that our child] is properly diagnosed."</p>
Needs Services of ED	12/75 (16%)	<p>"We didn't want to go somewhere else and then be sent here because she needed further attention." [from the mother of a 3 year old who was diagnosed with a contusion of the head.]</p> <p>"The staff at the ED know what to do and have the equipment."</p>
Past ED Use	3/75 (4%)	<p>"We have always brought all our children to this ED."</p> <p>"My family has used this ED since it opened...the hospital has always been good to us."</p>

* Responses from those parents who answered the open-ended questions (n=75). Some parents gave more than one reason.

majority of parents were either unsure of or overestimated the seriousness of their child's symptoms. Several studies have documented the low correlation between patient's perceived seriousness as determined by survey and actual morbidity as measured.¹²⁻¹⁴ Printed materials were not commonly used, perhaps suggesting that parents require access to more individualized professional advice to assist them to determine the seriousness of symptoms and the treatment required.

Professional advice, however, was not always readily available to the study participants. Almost half of parents who attempted to call their physician were unable to access advice. Some research has shown that contacting family physicians can decrease non-urgent ED use.^{15,16} In our

study, however, almost all parents who were able to access their physicians were referred to the ED. Referrals to the ED also were generated by ED personnel, particularly ED nurses. Inappropriate ED use patterns may be established when community physicians, ED physicians or ED nurses encourage parents to take their children to the ED for non-urgent care.¹⁴

The parents' inability to access professional services and the high numbers of professional referrals to the ED suggest a need for more accessible effective primary care services in the community. In other studies, non-urgent ED use also has been linked to the accessibility and availability of community-based ED alternatives, convenience, and the perception that the ED provides quality non-urgent care.¹³⁻¹⁵

Currently, there is renewed interest and emphasis on strategies that can increase accessibility to primary care services on a 24-hour, 7-days-a-week basis.¹⁷⁻²⁰ In Canada, the newly released CIHI report, *Health Care in Canada 2001*, calls for enhanced access to primary care on a 24/7 basis.²¹ In September 2000, Canada's First Ministers agreed to continue to make primary care reform a high priority. Access to 24/7 first contact health services was identified as one of 14 indicators to track changes in health care.²¹

Various strategies to enhance access to primary care services have been advocated. The Clair Commission in Quebec recommended family physician group practices that offer around-the-clock services.²² More commonly, a multidisciplinary team approach is advocated, such as the Primary Health Service Teams recommended by the Saskatchewan Fyke Commission.²³ Around-the-clock telephone health advice is an emerging service for accessing advice for non-urgent health situations. Currently, telephone triage services, generally staffed by trained nurses, are operating in several provinces (BC, ON, NB, PQ, AB). These services appear to be filling a need in helping the public to access information regarding symptom management and hold promise for decreasing ED use.²³ For example, Quebec's Info-Santé, which was used most frequently by women with young children, reduced both ED and physician use. In BC, of the 33% of callers to the information line who initially said they intended to use the ED, over half changed their minds after talking with the service about their symptoms.²³

Primary care clinics, such as medicentres, have also been advocated to decrease non-urgent ED use.¹⁵ Our study, however, suggests that parents must perceive that these clinics will provide the quality and type of care that they feel is required to address their health needs. A survey on non-urgent ED patients in Montreal also showed that even though respondents were aware of the walk-in clinics, 60% felt that the ED was still the best place for them to receive care.²⁴

Although much of the literature emphasizes strategies to decrease non-urgent use of the ED, there are those who suggest that making non-urgent care a legitimate part of the ED services may be a viable solution

in some contexts.²⁵ "Fast-tracks" are designed to speed non-urgent patients through the ED by diverting non-urgent patients from the trauma area to another area, where they are seen by general practitioners (or other primary care providers, such as nurse practitioners). An early assessment of such a program introduced in Saskatchewan reported patient satisfaction with the service.³

The major limitation of this research is its lack of generalizability. The data were collected from a convenience sample of parents who brought their children to one ED during a single two-week period. However, many of the study findings are supported by research in other settings, although comparability may be hampered by the use of inconsistent definitions of "non-urgent" use. Whether nursing care time, as in the EWMS, is the most appropriate measure to determine non-urgent care requires further review.

These findings point to potential areas for further research to more completely understand the issue of non-urgent care. Although the study provides a beginning understanding of the care-giving and care-seeking behaviours of parents who chose to use the ED, greater insight into the process of parental triage would be enhanced by also exploring the care-giving and care-seeking behaviour of those parents who did not attend the ED but chose to care for their children at home or who brought their children to community-based ED alternatives. The high numbers of professional ED referrals also warrants further investigation in relation to the factors that influence professional decision-making.

In spite of its limitations, this study provides new information regarding parents' care-giving and care-seeking behaviours preceding use of the ED for non-urgent care. The study points to the need for enhanced accessibility to primary care services that provide advice, support, and care when children are ill or injured.

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RÉSUMÉ

Objectif : Notre étude porte sur les soins prodigués et recherchés par des parents ayant amené leur enfant à l'urgence d'un grand hôpital urbain de l'Ouest canadien.

Méthode : Nous avons recueilli des données auprès d'un échantillon de commodité de 114 parents au cours d'une période de deux semaines, en janvier 1992, à l'aide d'un questionnaire à remplir soi-même comportant 53 questions. Nous avons analysé les données à l'aide de variables non paramétriques (khi-carré) et étudié leur contenu thématique.

Résultats : Quatre-vingt-deux p. cent des parents ne connaissaient pas très bien ou avaient surestimé la gravité de l'état de leur enfant. Avant de se rendre à l'urgence, 40 % avaient administré des mesures de bien-être à leur enfant, et 45 % leur avaient donné des médicaments. Seuls 17 % des parents avaient consulté des documents à lire à la maison, et 31 % avaient demandé conseil à des profanes. Cinquante-huit p. cent des parents n'avaient pas essayé de téléphoner à leur médecin de famille ou à l'urgence avant de se rendre à l'hôpital. Des parents qui avaient appelé leur médecin de famille, 48 % n'avaient pas réussi à obtenir des conseils, et les autres avaient presque toujours été aiguillés vers l'urgence. Quatre-vingt-huit p. cent des parents ayant téléphoné à l'urgence avaient reçu l'instruction d'y amener leur enfant.

Interprétation : Ces résultats suggèrent qu'il faudrait instaurer des services communautaires de soins de première ligne accessibles et de bonne qualité.