**Introduction**

 This paper explores the clinical perception of ‘inappropriate’ attender in the child population. The preservation of the health and wellbeing of children during minor illness is a subject of importance, in terms of the social and physical ill health that may be prevented and resource implications for the NHS and wider society (MacFaul *et al.*, 2004; Department of Health[DH], 2009). Childhood illness causes parental concern which may manifest in multiple health service contacts (Maguire *et al.*, 2011). The highest consultation rates are found among children age 0-4years (Hobbs *et al.,* 2016). Children under 5 years account for approximately 40% of GP consultations (DH, 2010b), most of which are related to acute illness (Hippisley-Cox and Vinogradova 2009; RCGP, 2007). The aim of this review was to explore the concept of parental self-efficacy (PSE) during episodes of acute minor childhood illness and to understand the extent to which the practitioner can influence PSE.

The perception of the ‘inappropriate’ attender in the Emergency Department (ED) and Urgent Care is not new (Breen, B.M. and McCann, M. 2012; Dewey and Hawkins, 1998; Murphy, 1998; Platt, 1962; Wyke *et al.*, 1990; Hallam, 1994; Hopton *et al.*, 1996;), this concept evaluates the appropriateness of consultations based upon medical need (Anderson *et al.*, 1980; Morrell *et al.*, 1980; Sides, 1988). The term ‘inappropriate’ is misleading as an accepted definition of the components of an emergency does not exist (Murphy, 1998; Morgans and Burgess, 2012; Breen and McCann, 2013). Morgans and Burgess (2012) identified a marked difference between medical classifications of the physiological urgency and a patient-based assessment of urgency, which is defined by mainly psychosocial factors. Past evidence has indicated families look after children with minor acute illness without professional help for between 59 and 99 percent of episodes of acute illness at home (Bruijnzeels et al., 1998; Holme,1995; Mayall, 1986; Saunders et al., 2003). The belief that there is a direct link between education and the use of health services is problematic, as there is a lack of compelling evidence to support this view (Atenstaedt *et al.,* 2014; Heaney *et al.*, 2001; Little *et al.*, 2001; Neill *et al.,* 2015 ). Nonetheless, studies continue to explore how to encourage appropriate attendance through education (Breen and McCann, 2013; Ismail *et al.*, 2013).

The National Service Framework for Children, Young People and Maternity Services (DH, 2007) acknowledged that more needs to be done to enable the optimum health and well-being of children by focusing on new approaches to delivering children’s healthcare services. Within the context of limited healthcare resources, parental ability to promote the health and well-being of their child effectively is of national importance (Purssell and While, 2013). Coleman and Karraker (1998) identified that a significant element of parenting is ‘Parental Self-Efficacy’ (PSE). This builds on the principles of SE (self-efficacy) described by Bandura (1977).

**Background**

In the 1970’s Bandura introduced the concept of SE which has causal effects on human functioning across numerous behavioural domains (Bandura, 1997). Initially identified within the bounds of psychology as holding a pivotal role in social cognitive theory (Bandura 1997), SE has become notable in health and social policy (DH, 2005, 2009, 2010a). Bandura (1997, p.3) defines perceived SE as ‘the belief one holds in one’s capabilities to organize and execute the courses of actions required to produce given attainments’. Bandura (1982) and Teti and Gelfand (1991) suggest that the relationship between SE and performance is best described as bidirectional. Self-efficacious people tend to persist in a given task until success is achieved, whereas people lacking SE will give up prematurely. In turn SE beliefs are increased or decreased by success or failure experiences. Performance attainments are viewed as those experiences that are most likely to impact on SE beliefs, however other sources also have impact such as vicarious experiences, verbal persuasion, and psychological states (Bandura, 1982, 1989).

SE can forecast the extent to which an individual can control their health behaviours such as preventative dental practices, effective breast self-examination, adoption of healthy eating, exercise and smoking cessation (Beck and Lund, 1981; Alagna and Reddy, 1984; Brod and Hall, 1984; Kaplan *et al.*, 1984; Sallis *et al.*, 1988; Conner and Norman, 2005). The relationship between PSE and parental management of chronic health conditions in children is a more recent topic of research (Mitchell and Fraser, 2011). Emerging evidence suggests that PSE predicts the performance of disease-specific management tasks, for example in the management of childhood asthma (Chiang *et al.*, 2003; Chiang *et al.*, 2005; Hansel *et al.*, 2006; Van Dellen *et al.*, 2008; Brown *et al.*, 2014) and cystic fibrosis (Bartholomew *et al.*, 1993; Jamieson *et al.,*2014). A research base considering PSE in relation to health care is established in health visiting practice, yet relatively new to other areas of nursing (Whittaker and Cowley, 2012).

PSE involves both the level of knowledge about child-rearing tasks and the degree of parental confidence in the ability to perform these tasks (Coleman and Karraker, 1998). PSE can also play an important mediational role between parental factors (e.g mental health, childrearing experience), child characteristics (e.g. health, disposition) and situational factors (e.g. deprivation, social support) (Donovan and Leavitt, 1985; Cutrona and Troutman, 1986; Bugental and Cortez, 1988; Coleman and Karraker, 1998). Nonetheless, a knowledge base that specifically addresses the concept of PSE in relation to acute childhood illness was not identified. This review places PSE as the central concept in managing acute childhood illness. All other related terms and theories were scrutinised, to explain and explore the theoretical and practical applications for clinicians working in urgent and primary care.

**The Integrative review:**

This integrative review utilised Whittemore and Knafl (2005), and Torraco’s (2005) framework to guide methodological rigour (Ganong, 1987; Torraco, 2005). A description of the research process is feature in table 1.

|  |  |  |
| --- | --- | --- |
| **The Research Process** | **Possible confounding factors** | **Attempts to redress confounding factors** |
| **Identification of the research question** | * The thinking processes of the researchers, assumptions made and theoretical stance (Parahoo, 2006). * Defining the key terms and concepts needed to compose the question (Parahoo, 2006). | * Wide reading of seminal and up to date evidence on the topic, university led discussions, conversation with colleagues, and meetings with the co-author. * Meetings with university librarian to formulate the terms for the question. * Many practice searches. |
| **Collection of data** | * Choosing a design and conceptual framework (Parahoo, 2006). * Identifying target population. | * Bandura’s (1997) theory on SE was initially the focus following an extensive review of the subject, but the search was expanded as similar concepts emerged that were also relevant to the question. |
| **Analysis of data** | * Decisions about the type of analysis (Parahoo, 2006). * Critiquing comprehensively. | * Discussions with the co-author, colleagues and university led meetings. * Selection of a detailed critical appraisal tool which is applicable to the selected research. |

**Table 1 The research process guided by Parahoo (2006)**

**Aim:**

* To investigate the implications of PSE during episodes of acute minor childhood illness.
* To explore the role of the practitioner in influencing PSE.
* To indicate a direction for further research.

**Design:**

The literature relating to Bandura’s (1977) concept of SE was explored in conjunction with an appraisal of more up to date research. In addition current evidence linking PSE to acute minor childhood illness was reviewed.

**Search Strategy**

A multi-stage analytical approach was used to search for primary literature. This included keyword searching of electronic databases, methodically checking the reference lists of identified papers and hand searching of relevant publications (Conn *et al.*, 2003). Terms were searched as keywords to identify all relevant research. Databases searched included CINHAL, Scopus, Cochrane Library, PsychINFO, MEDLINE, Research Starters, Science Citation Index, Social Sciences Citation Index, sciELO, ERIC, SocINDEX, JSTOR and AMED. Data bases were searched jointly on Delphis. Inclusion and exclusion criteria were developed prior to the search using the PICO (participants, interventions, comparators, outcomes) tool (Shamseer et al 2015).

While the initial topic considered was SE (Bandura, 1977), the search expanded when similar concepts emerged that had significance to parental management of minor illness. These were therefore included in the search to avoid missing relevant papers. The search terms are listed in figure 1.

**Results**

Figure 1 search terms

**Search terms:**

* barrier\* OR obstacle\* OR hurdle\* OR difficult\* OR impediment\* OR block\*

AND

* “locus of control\* OR psychosocial\* OR “health visit\*” OR “health belief\*” OR “health care deliver\*” OR “self car\*” OR “self-car\*” OR efficacy \* OR “self efficacy\*” OR “self-efficac\*” OR “self belief\*” OR “empower\*” OR confiden\*

AND

* paed\* OR ped\* OR bab\* OR toddler\* OR “pre-school\*” OR infant\* OR son\* OR daughter\* OR child\* OR dependent\* NOT teen\* NOT adoles\*

AND

* "childhood illness\*" OR "sore throat\*" OR pharyngitis\* OR cough\* OR fever\* OR "common cold\*" OR influenza\* OR rash\* OR "ear infection" OR otitis media OR gastroenteritis\* NOT obes\*

AND

* parent\* OR maternal\* OR paternal\* OR mum\* OR dad\* OR mother\* OR father\* OR mom\*

After the removal of duplicates 1082 papers were initially found, the PRISMA (Liberati et al., 2009) search strategy was used to identify papers to review. This is demonstrated in figure 2.

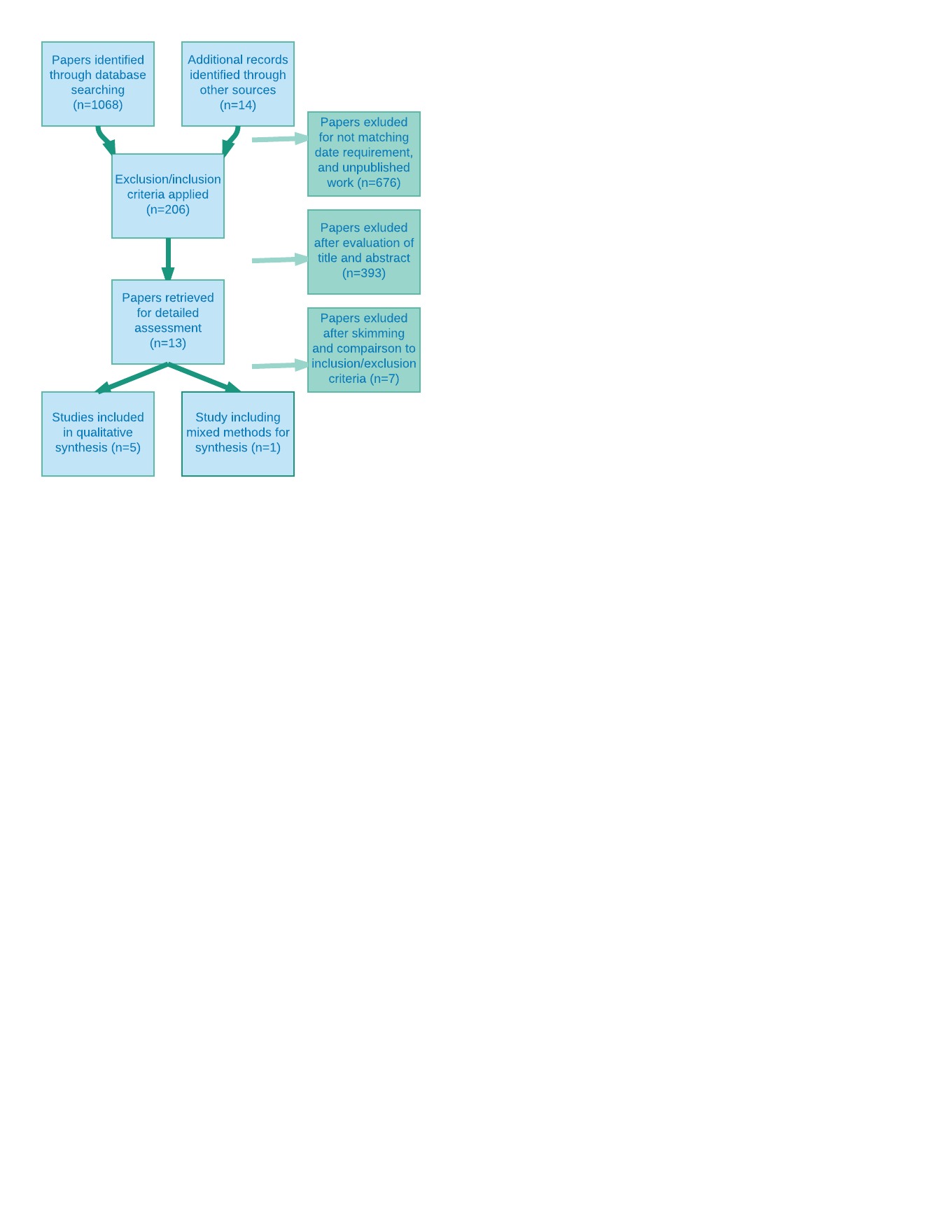


Figure 2 Research Process diagram based on PRISMA (Liberati et al, 2009)

6 papers were finally selected as meeting the inclusion criteria. Then to support the fusion of narrative and statistical information (Whittemore, 2005), data and findings were extracted into an evidence table (Table 1). 4 papers adopted a qualitative research approach, 1 undertook mixed methods, and 1 used qualitative mixed methods.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Reference** | **Focus** | **Place** | **Sample** | **Methods** | **Findings** |
| Callergy et al 2013 | To examine the care provided by community children’s nurses during acute illness. | UK | 763 questionnaires and 81 semi-structured interviews- no mention of gender distribution | qualitative mixed methods | \* Nurses can make an important contribution to supporting parents to care confidently for their children at home to reduce or even avoid hospitalisation for acute conditions .  \*Health professionals’ advice and education can enhance parents’ confidence to care for their children during acute illness and to manage future episodes of illness . |
| Ingram et al 2013 | To explore parents’ perceptions relating to decision making about when to consult when child is ill with RTI. | UK | 7 focus groups and 30 interviews, Mothers:21 Fathers:2 | qualitative | \*Personal threat of cough to the child as perceived by parents included combination of severity of illness and susceptibility of the child.  \*Information sought to support self-care and increase PSE to care for the child at home by all parents to identify when to worry.  \*Parents sought specific advice about current circumstances.  \*Friends and family were important sources of information.  \*Re-attendance was often because initial consultation was beneficial in providing evaluation, reassurance and knowledge.  \*Parents want to understand a child’s illness better and have reassurance.  \*Practitioners should provide information that promotes PSE in the care of their child.  \*Parents’ experience, confidence and efficacy influence likelihood of consulting with RTI. |
| Maguire et al 2011 | To explore how parents navigate urgent and emergency care when their child has a feverish illness. | UK | 220 parents, no mention of gender distribution. | mixed methods | \*Attendance was not due to “doctor shopping” but often due to referral between services.  \*Fragmentation of urgent and emergency care leading to multiple assessments.  \*Value of safety netting was highlighted as when this was given parents were less likely to re-attend.  \*Parents aware of service options available.  \*Parents want explicit and consistent advice for home management. |
| Neill et al 2013 | Exploration of the management of acute childhood illness (ACI) at home | UK | 29 interviews, Mothers: 15 Fathers:13 | qualitative | \*Parental decision making can be impaired by felt or enacted criticism.  \*Experiencing positive regard increases self-esteem and is likely to increase SE in managing ACI at home. |
| Speirs et al 2011 | Parents’ psychosocial experience of receiving care closer to home (CCTH) for their ill child. | UK | 22 interviews with 28 parents/carers, Mothers: 20 Fathers: 13 | qualitative | \*Parents mainly positive about CCTH and valued being well supported.  \*Parents respond differently to their responsibilities in CCTH.  \*Parents can receive peer support while their child is in hospital, community nurses fill this role when cared for at home. |
| Winskill et al 2011 | An exploration on the factors parents monitor when interpreting their childs’ illness and how they respond. | Aus | 25 questionnaires Mothers:92% Fathers:8% | qualitative | \*Parents make every effort to see a GP rather than attending ED.  \*Investigations in ED demonstrate reliability of parental perceptions of illness.  \*Parents frequently focus on deviation from normal behaviour to judge level of sickness rather than fever alone.  \*Parents value health professionals’ assessment of a childs’ illness.  \*Parents should be credited for appropriate use of ED.  \*Parents’ expressions of their perceptions of childs’ illness and underlying rationale should be listened to.  \*Working collaboratively with parents is important. |

Table 2 Evidence Table

**Appraisal/Quality Appraisal**

The next step was to critically review the 6 papers. Critical appraisal tools provide analytical evaluations of the quality of the paper, particularly the methods applied to minimise bias in a research project that can be applied across study types. A gold standard critical appraisal tool does not exist nor is there any widely accepted generic tool (Katrak *et al.*, 2004). After considering a variety of appraisal tools , the papers were critiqued using the framework identified by Cluett and Bluff (2006). Cluett and Bluff’s framework enables the reviewer to consider a paper regardless of paradigm, and to carry out an in depth analysis of each stage of the research design.

**Synthesis/Abstraction & Synthesis**

The data extracted from the papers was then coded (Braun and Clarke 2006 see figure 3).

**Coding Method**

* The coding was done manually by using post-it notes to identify segments of data.
* Thematic analysis emphasizes pinpointing, examining and recording patterns or themes (Braun and Clarke 2006).
* This method was undertaken by colour coding all documented findings in terms of the quality of papers, then grouping them according to similarities.

Figure 3 Coding method

Themes were then compared taking care to accurately represent the context of the original paper and to prevent disruption of the original significance (Walsh and Downe, 2005). Following synthesis of the results six themes emerged. These feature in Table 2.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Themes** | **Findings** | **Callergy et al 2013** | **Ingram et al 2013** | **Maguire et al 2011** | **Neill et al 2013** | **Spiers et al 2011** | **Winskill et al 2011** |
| **Appropriateness of Attendance** | * Parents responded appropriately to the altered behaviour of their child, their decision making was based on the illness and the choices available * Parents sought advice from a variety of sources prior to attendance * Many attendances were generated by referrals between services |  |  | **Y**  **Y** |  |  | **Y**  **Y**  **Y** |
| **Listening to Parents** | * Parents prefer to care for their child at home * Being listened to and working collaboratively with health professionals was rated as important * Parental accounts indicated a complex, multifaceted experience, listening to perceptions of illness and rationale are valued |  |  |  |  | **Y**  **Y**  **Y** | **Y**  **Y** |
| **Reassurance** | * When parents return with the same illness episode, the consultation itself was seen as beneficial for medical evaluation, reassurance and providing knowledge * Reassurance is valued by parents * Knowledge provision and support contribute to the feeling of reassurance |  | **Y**  **Y**  **Y** |  |  | **Y**  **Y**  **Y** | **Y**  **Y** |
| **Perception of illness** | * Things that influence parental awareness of illness are based upon a combination of factors such as deviation from normal behaviour and others signs and symptoms * Parents are not worried about consulting for minor illness * Parental decision making can be hampered by experience of breaching informal social rules |  | **Y** |  | **Y** |  | **Y** |
| **Safety-netting** | * Parents want safety-netting advice to be explicit, consistence and tailored to the circumstances * Safety-netting was more consistently provided to those children who were more seriously unwell * Practitioners play a major role in providing parents with information about over the counter medication, and the value of safety-netting is highlighted |  | **Y** | **Y**  **Y**  **Y** |  |  |  |
| **Parental Learning** | * Practitioners should provide consistent information that promotes PSE in the care of unwell children * Parental experience, confidence and efficacy influence the likelihood of seeking a consultation for their child * The advice and education provided by health professionals can enhance parental confidence to care during acute illness, and to attempt self-care in future episodes | **Y** | **Y**  **Y** |  | **Y** |  |  |

Table 2 Themes Identified

**Discussion**

The review identified 6 specific themes relating to PSE is acute childhood illness. These themes will each be explored looking at thematic interrelationship and the message for practitioners.

***Appropriateness of attendance***

Of the 6 papers reviewed, 3 identified that parents undertake a complex decision-making process prior to attending with their child for assessment (Maguire *et al.*, 2011; Winskill *et al.*, 2011; Ingram *et al.*, 2013). The reliability of parental perception was considered appropriate and substantiated by investigations carried out by clinicians (Winskill *et al.*, 2011). 2 papers identified that parents are accurate in judging when their child needs a medical review (Maguire *et al.*, 2011; Winskill *et al.*, 2011).

***Perceptions of illness***

Contrary to the perception of some service providers that high attendance rates with febrile illness were due to ‘doctor shopping’, parents who are seeking advice are often being referred between services (Maguire *et al.*, 2011; Winskill *et al.*, 2011). Parents make decisions after speaking to NHS Direct or a GP practice before being referred to Accident and Emergency or the Out of Hours service (Maguire *et al.*, 2011; Winskill *et al.*, 2011). This can result in multiple service contacts and raises questions about whether some new services are really cost effective (Maguire *et al.*, 2011).

***Listening to parents, safety-netting, reassurance and parental learning***

|  |  |  |  |
| --- | --- | --- | --- |
| Performance Accomplishments | Vicarious Experience | Verbal Persuasion | Emotional Arousal |
| • Appropriateness of attendance: |  |  |  |
| •Listening to Parents |  |  | **•**Perceptions of illness |
| •Reassurance |  |  |  |
| •Parental learning |  |  |  |
| •Safety netting |  |  |  |

Parents attend because they want medical evaluation, reassurance, to gain knowledge about how to look after their ill child, and to gain information about what to look out for (Winskill *et al.*, 2011; Ingram *et al.*, 2013). Parents also value support (Spiers *et al.*, 2011) and guidance (Callery *et al.*, 2013). Table 3 demonstrates how practitioners can influence PSE in relation to the findings and Bandura’s (1977) description of the concept.

Table 3 Themes which resulted from synthesis of papers arranged according to Bandura (1977) SE theory

The themes identified within this review (table 3) are congruent with Bandura’s (1977) research. It is also worth mentioning a key finding of Neill et al (2013) paper that overlaps several themes but does not constitute a theme of its own. She found that repeated exposure to felt or enacted criticism by practitioners in primary care may reduce PSE, this results in a reduction in parental ability to manage acute minor childhood illness (Neill et al., 2013) Positive parental regard has the potential to reduce consultations in primary care and the emergency department (Neill et al., 2013). Neill et al’s (2013) work highlighted that parental decision making can be hampered by experience of breaching informal social rules. Parents can feel criticism either if they are perceived to have attended unnecessarily, or if they delay appropriate attendances (Neill et al, 2013).

By offering positive regard to parents, listening, enabling them with learning tailored to their need, and by providing specific safety netting advice, clinicians can assist parents in developing parenting ability through encouragement of PSE. Knowledge of factors that decrease PSE such as parental experience of criticism, referrals between service and increasing anxiety can help clinicians avoid these pitfalls. The concept ‘inappropriate’ attender can influence staff to provide care which effectively diminishes PSE in parents.

**Implications for practice**

Nurses have an important role in the management of Urgent Care. Practitioners may need to focus on interventions that involve the four sources of SE (see table 5, Bandura, 1977). Knowledge of the six topics which feature in the material reviewed can help strengthen consultation skills, resulting in more effective interventions with this patient group. It could be helpful to create and distribute an aide-memoire for this purpose. This is a powerful message that needs to reach educators, policy makers, commissioners and front line practitioners.

Questions are raised about where parents are to get the support, knowledge and the advice that they are seeking if not in these settings? The evidence accessed for background and within the appraisal strengthens the need to listen to parents when they are worried about their child. Indeed one of the recommendations which resulted from the recent root-cause analysis regarding the death of child was that parental concerns were not listened to (NHS South, 2016), which emphasizes the importance of this aspect of patient care. It would be helpful to consider alternate means of meeting the needs of parents. For example looking at the potential for a greater involvement of children’s nurses in primary care to support parents in developing PSE before the need to access health assessment. More investment in this area could be financially beneficial if parents can access help and advice closer to home, without the need to visit A&E or the OOH service. More research of this topic would be advantageous to both parents and health services.

**Strengths & limitations**

As with all reviews the findings were constrained by the quality and scope of the research included. Within most of the papers referring to parents, the majority of participants were Mothers (see table 1) which could have confounded the results of these papers. However this does roughly reflect the demographics of primary carers currently within the UK (Walling, 2005; Judiciary., 2013; Horizons., 2015). It would however be beneficial to have more Fathers represented in future research.

Some of the research looked at the specific subject area of self-efficacy and acute minor childhood illness, but others were from related or similar concepts. As a result some of the analysis was challenging, making it difficult to draw clear conclusions. Nonetheless the variety of concepts used in the papers did not detract from the voice of parents emerging from the qualitative research undertaken which comprised all but one of the papers reviewed. The findings indicate that parents are making good decisions, wanting to do the right thing, and looking for ways to provide better care.

**Conclusions**

Most of the research looking at how to reduce medically nonessential attendance, with acute minor childhood illness has been guided by a medical model. This involved focussing on what needs to be taught to parents to prevent consultations, rather than considering that the service provided is not meeting their needs. If consideration by front-line practitioners, researchers and teachers could be given to PSE and how this fits in to consultations the care provided in the front line could improve. It would also be beneficial to parents and NHS budgets if more children’s nurses and health visitors were involved in services aiming at boosting the PSE of new parents. Too much focus on parental management of these illnesses has not been considered in relation to the evidence, but rather focused on the concept of ‘inappropriate’ attender. It would be useful to look at ways of boosting PSE during consultations, and to focus on interventions which might support parents in a more effective way. Despite medical opinion that there is a phenomenon of non-essential attendance, the papers reviewed suggest that parents seek medical advice for acute minor illness based on considered decision-making. Conversely, dismissive attitudes by primary care professionals reduce PSE and exacerbate the need for professional review.

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