**Objective** To improve communication, discharge readiness, and satisfaction of burn patients and their families.

**Methods** In March 2009, the burn intensive care unit at University of Louisville Hospital, Louisville, Kentucky, incorporated family presence during dressing changes. Adverse family events during observation, measures of patient- and family-centered care according to a standardized patient satisfaction survey, infection rates, and staff members’ response to the intervention were tracked.

**Results** Through December 2011, no adverse family events occurred, patients’ satisfaction scores increased, and infection rates did not increase. Staff members responded positively to the project.

**Conclusions** Allowing family presence during dressing changes provides an opportunity to educate and include patients’ family members in care delivery.


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Burn injuries can be devastating to both the patients affected and the patients’ families who support the injured person. Severe burn injuries can affect patients for a lifetime, leaving them with lifelong disabilities and chronic health conditions. In an effort to shield patients’ family members from an anxiety-provoking experience and protect the patients from potential infections, burn units have historically restricted visitation during dressing changes. Evidence indicates that these restrictions contribute to patients’ and family’s dissatisfaction and to their knowledge deficit when it comes time to care for burn patients at home.

A major factor adding to the anxiety felt by hospitalized patients and their families is the fear that health care providers withhold important information about a loved one. Research has shown that both patients and their families feel it is their right for family members to be present during procedures (family presence) and that both groups “would like the option to participate.”

A patient’s family members want to know what is going on, have questions answered honestly, and see the patient frequently. Informational support has a positive correlation with families’ satisfaction with care ($r = 0.741; P < .001$). Family members who participate in care perceive more respect, collaboration, and support than those who do not.
In a study by Sproul et al, 87.8% of burn patients reported family support as very important to the patients’ recovery. In addition, Muangman et al reported that social support was a possible contributor to burn patients’ in-hospital survival rates. In that study, 81% of patients who survived until discharge had some social support, compared with only 35% of nonsurvivors (P = .007). Family support can also decrease the risk of long-term psychosocial issues, such as financial burden, depression, posttraumatic stress disorder, and anxiety, in burn survivors.

Family presence during procedures has been studied more in children (patients <20 years old) than in adults. According to Mangurten et al, 89% of pediatric health care providers think that patients’ family members should have the option of being present during procedures. In addition, parental presence can reduce anxiety and pain during burn dressing changes. Despite these findings, parental presence is still not routine during these procedures. The literature reflects a dichotomy between health care professionals’ perceptions and practice regarding family presence.

For adult patients, 69% of health care providers think that patients’ family members should be present during procedures. Opinions on the extent of family presence and on how to implement the concept into practice vary among practitioners. Fear that infection rates will increase and that patients’ families will be unable to tolerate the procedures are 2 common reasons for not allowing family presence during dressing changes. Nevertheless, in a study by Byers et al, adult patients who had family present during burn dressing changes had greater reduction in both pain and anxiety than did those who did not have family present (P = .01).

With increased survival rates and decreased length of stay, burn patients are being discharged from the hospital while still requiring complicated care. The patients’ family and friends are identified as important sources of support and are often asked to perform daily dressing changes, including dressing removal, wound cleansing, and redressing, at home, with little or no preparation. Primary concerns patients identify when being discharged are recognition of wound complications and infections and treatment of wound pain. Discharge readiness is a complex issue that involves attention to patient-specific variables, including education, psychosocial evaluation, and home environment. In order to support both patients and their family members for the transition home, everyone, not just health care personnel, must be involved in the delivery of care during the patients’ hospital stay.

Additionally, a query sent to the American Burn Association listserv about family participation in dressing changes elicited responses from 21 different adult burn units in the United States. Among those units, only 19% allowed family presence during dressing changes from admission to hospital discharge.

University of Louisville Hospital, Louisville, Kentucky, has adopted patient- and family-centered care (PFCC) as its professional model. In the PFCC model, optimal care is understood to be the collaboration between health care professionals, patients, and patients’ families. According to the Institute for Patient- and Family-Centered Care, the term family is defined as anyone a patient identifies as family, whether the person is legally, biologically, or emotionally connected to the patient. PFCC is based on the premise that a patient is an extension of his or her family unit and that the family is integral to the patient’s overall health and well-being. The core concepts of PFCC include dignity and respect, collaboration, participation, and information sharing. These core concepts promote self-determination, involvement in decision making, control over care, and self-efficacy for both patients and their families.
The University of Louisville Hospital is a 404-bed urban level I trauma academic medical center. The 5-bed burn intensive care unit admits a mean of 130 burn patients per year; the mean length of stay is 7.23 days. According to the hospital trauma registry, the mean total body surface area burned is approximately 14%, and the prevalence of inhalation injury is 20%.

On the hospital’s burn unit, traditional practice dictated that visitors were not allowed to be present during dressing changes until just before a patient’s discharge, consistent with the national trend indicated by the response to the query sent to the American Burn Association listserv. The burn unit’s practice was inconsistent with the hospital’s PFCC model. Embracing the core concept of participation by family presence during dressing changes provided an opportunity to improve how care and education are delivered to patients and families in a burn unit.

While discussing potential changes in the unit’s practice, nurses and physicians expressed apprehension about being watched or judged while performing the dressing changes. Concerns were also voiced about a family’s ability to tolerate seeing the wounds. To address these concerns, nursing leaders reminded staff of the vital importance of patient and family education for improved patient outcomes.22,23

The nursing staff of the burn unit invited patients’ family members to be present during dressing changes. This change in practice was meant to address the question of whether family presence during dressing changes would

- Increase opportunity for communication and education about a patient’s plan of care
- Improve a patient’s readiness for discharge
- Increase satisfaction of patients and their families.

In this article, we describe the process of incorporating family presence during dressing changes and share the outcomes of the initiative. Our goal is to illustrate the benefits and challenges associated with family presence during procedures, such as burn dressing changes, in critical care patients and to add our findings to the body of knowledge on this issue.

Methods
A comprehensive literature review was conducted before implementation of the change and periodically thereafter as new evidence became available. The databases searched were PubMed, CINAHL, and Ovid. Search terms included burns, dressing changes, family presence, critical care, patient- and family-centered care, and discharge. After a thorough review of the search results, 25 articles and 2 Internet-based resources were found that met criteria for use in this quality improvement project. Criteria included peer-review articles in English specific to the search terms. Table 1 is a summary of the referenced literature.

After discussions about incorporation of family presence during burn dressing changes among nursing leaders, burn unit staff, and physicians, the decision was made to allow a patient’s family to observe dressing changes throughout the patient’s hospitalization, starting in March 2009.

Staff approached each patient, or authorized designee if the patient was unable to make decisions on his or her own behalf, to offer the opportunity to observe dressing changes. If the patient and family wished to participate, a nurse then provided education on what to expect during the dressing change procedure. Details such as administration of medications, dressing removal, cleansing of the skin, application of topical medications, and redressing the wounds were explained at length. In addition, safety issues were discussed, including techniques such as hand washing to prevent infections and instructions to family members to sit down or exit the room if they become physically uncomfortable (eg, nauseous, lightheaded) while participating.

While participating, staff members were instructed to follow the hospital’s emergency medical assistance policy if a family member experienced a medical emergency during the procedure.

The family was instructed how to dress in personal protective equipment, including isolation gown, mask, cap, and gloves, before entering the patient’s room. During the dressing change, the nurse and physical therapist, a certified wound specialist, provided education and allowed for discussion of the care being provided. Afterward, the nurse reviewed the process with the family to allow for clarification and verify understanding.

After family members had been present during a dressing change, the manager of the burn unit spoke with the patient (when possible), the family, and staff about the impact of the family presence. Questions included inquiries about both the
### Table 1 Literature review

<table>
<thead>
<tr>
<th>Year</th>
<th>Author(s)</th>
<th>Purpose</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1974</td>
<td>Brodland and Andreason*</td>
<td>Examine adjustment problems of families of adult burn patients</td>
<td>Patients’ emotional reactions may cause distress; families may have unrealistic expectations about appearance.</td>
</tr>
<tr>
<td>1984</td>
<td>Reddish and Blumenfield*</td>
<td>Describe behaviors and responses of wives to their husbands’ burn injuries</td>
<td>Wives may feel panic in early stages and be concerned about pain and physical appearance, may perceive role changes positively.</td>
</tr>
<tr>
<td>2001</td>
<td>Byers et al**</td>
<td>Examine burn patients’ pain and anxiety experience during resting conditions and procedures</td>
<td>Family presence correlated with decreased procedural pain ($P = .01$) and midazolam use ($P = .047$).</td>
</tr>
<tr>
<td>2002</td>
<td>Bruce et al*</td>
<td>Improve understanding of health professionals’ perceptions and current practices of the elements of family-centered care</td>
<td>General significant differences were demonstrated between health professionals’ perceptions and practices of family-centered care.</td>
</tr>
<tr>
<td>2004</td>
<td>Wagner*</td>
<td>Describe the experiences, thoughts, and perceptions of family members of critically ill patients during cardiopulmonary resuscitation in the intensive care unit</td>
<td>Health care professionals neglect to recognize that patients’ family members are experiencing crisis and that coping mechanisms are impaired; family members’ information and proximity needs are often ignored during this time of crisis.</td>
</tr>
<tr>
<td>2004</td>
<td>Willebrand et al*</td>
<td>Explore predictive value of general coping style, a subjective life threat, and reports of dissociation for postburn psychological well-being</td>
<td>Coping style, life threat during the accident, and early symptoms are strong predictors of psychopathology after a burn; burn severity was not predictive of psychological health.</td>
</tr>
<tr>
<td>2005</td>
<td>Mangurten et al**</td>
<td>Describe the process of implementation of written family presence policy in an emergency department</td>
<td>Recommend that family members be given an option to be with their loved ones during invasive procedures or resuscitative interventions.</td>
</tr>
<tr>
<td>2005</td>
<td>Muangman et al**</td>
<td>Determine other presenting factors that might indicate survival benefit for patients with large burns</td>
<td>Survivors were more likely than nonsurvivors to have social support ($P = .007$).</td>
</tr>
<tr>
<td>2006</td>
<td>Chien et al**</td>
<td>Examine the effect of a needs-based education program on the anxiety levels and satisfaction of psychosocial needs of family</td>
<td>Findings support the effectiveness of providing families of newly admitted critically ill patients with a needs-based educational intervention to allay anxiety and satisfy immediate psychosocial needs.</td>
</tr>
<tr>
<td>2006</td>
<td>Trantowski et al**</td>
<td>Describe attributes of burn patients as well as functional status that may be predictive of discharge destination</td>
<td>Functional Independence Measure locomotion was strongly predictive of discharge to home vs another setting; additionally, 57% of patients discharged to an inpatient setting did not have adequate social support at home.</td>
</tr>
<tr>
<td>2006</td>
<td>Wallis et al**</td>
<td>Assess emotional distress and psychosocial resources in patients with burn injury</td>
<td>Results showed greater values of emotional distress, anxiety, depression, and posttraumatic symptoms.</td>
</tr>
<tr>
<td>2007</td>
<td>Davidson et al**</td>
<td>To develop clinical practice guidelines for the support of patients and family members in the adult, pediatric, or neonatal patient-centered intensive care unit</td>
<td>Endorses a shared decision-making model, early and repeated care conferencing to improve consistency in communication, family presence, and open and flexible visitation.</td>
</tr>
<tr>
<td>2007</td>
<td>Duran et al**</td>
<td>Describe and compare the beliefs about and attitudes toward family presence of clinicians, patients’ families, and patients</td>
<td>Clinicians had positive attitudes toward family presence but had some concerns about safety, the emotional responses of family members, and performance anxiety; patients and their families had positive attitudes toward family presence.</td>
</tr>
<tr>
<td>2007</td>
<td>Pieper et al**</td>
<td>Examine patients’ wound care knowledge and concerns before discharge from an acute care hospital</td>
<td>Discharge teaching needs to begin early so that patients feel they have adequate time to learn and ask questions.</td>
</tr>
<tr>
<td>2008</td>
<td>Blankeney et al**</td>
<td>Review of issues associated with psychosocial care and treatment recommendations</td>
<td>Recovery may take up to 2 years after injury.</td>
</tr>
<tr>
<td>2008</td>
<td>Hanson et al**</td>
<td>Systematic review evaluating the benefits of nonpharmacological interventions to reduce distress in pediatric burn patients</td>
<td>Patient benefit was reported for interventions mediated by health care provider and child.</td>
</tr>
</tbody>
</table>

*Continued*
physical and the psychological impact of observing the dressing change. Any adverse events during family presence in a dressing change were tracked by the unit manager by using the hospital’s occurrence reporting system. An adverse event was defined as any reason a family member could not tolerate the dressing change, including, but not limited to, lightheadedness, fainting, nausea, and vomiting.

Patient satisfaction scores for the PFCC core concepts of information sharing, collaboration, and dignity and respect related to education, treatment decisions, and discharge were tracked by using a Press Ganey satisfaction survey after discharge. The survey uses a 5-point Likert scale. Results are reported as the percentage of respondents who answered the question as very good. The survey questions applicable to our goal of improved patient satisfaction and discharge readiness were as follows:

- How well the nurses kept you informed (PFCC: information sharing)
- Staff attitude toward your visitors (PFCC: dignity and respect)
- Extent to which you felt ready to be discharged (PFCC: information sharing)
- Staff effort to include you in decisions about your treatment (PFCC: collaboration)
- Instructions given about how to care for yourself at home (PFCC: information sharing)
- Overall rating of nursing care

Data on patients discharged from January 1, 2007, through February 28, 2009, before family presence was used, were used as the baseline. This information was compared with data collected from patients discharged March 1, 2009, through December 31, 2011.

In addition, to address the common concern about increased risk of infection, the hospital’s infection

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**Table 1 Continued**

<table>
<thead>
<tr>
<th>Year</th>
<th>Author(s)</th>
<th>Purpose</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>Park et al</td>
<td>Identify risk factors of psychosocial problems that prevent burn patients from adjusting appropriately after burn</td>
<td>Lack of family support and living expense burden were 2 significant risk factors for psychosocial problems.</td>
</tr>
<tr>
<td>2009</td>
<td>Mitchell et al</td>
<td>Evaluate the effects on family-centered care of having critical care nurses partner with patients’ families to provide fundamental care to patients</td>
<td>Partnering with patients’ families significantly improved the respect, collaboration, support, and overall scores on the family-centered care survey at 48 hours.</td>
</tr>
<tr>
<td>2009</td>
<td>Sacco et al</td>
<td>Describe the effectiveness of using families of former patients to facilitate support groups for current patients’ families</td>
<td>Families need communication with experienced families regarding what to expect during and after stays in the intensive care unit; emphasizes importance of including patients’ families in decision making.</td>
</tr>
<tr>
<td>2009</td>
<td>Sproul et al</td>
<td>Identify what factors adult burn survivors report as important during burn recovery; identify frequency and reported benefits of peer support, and determine the difference in the level of reported hope among burn survivors who received peer support and those who did not</td>
<td>Peer support has perceived benefits and may increase hope for burn survivors; family support is reported as very important in recovery.</td>
</tr>
<tr>
<td>2009</td>
<td>Wu et al</td>
<td>Describe the difference in coping strategies that affect psychological and physical rehabilitation in Chinese burn patients</td>
<td>Optimistic personality, positive coping styles, and social support played very important roles.</td>
</tr>
<tr>
<td>2010</td>
<td>Bailey et al</td>
<td>Describe family members’ perception of informational support, anxiety, satisfaction with care and their interrelationships, to guide further refinement of a local informational support initiative</td>
<td>A positive correlation was found between informational support and satisfaction with care ($r=0.74$, $P&lt;.001$).</td>
</tr>
<tr>
<td>2011</td>
<td>Sundara</td>
<td>Synthesize knowledge about the issues and concerns of families of adult burn survivors</td>
<td>Family issues include worries about their loved one’s physical appearance, logistical concerns, and the transition home.</td>
</tr>
<tr>
<td>2011</td>
<td>Smith et al</td>
<td>Compare nurses’ and caregivers’ perceptions of support interventions provided before, during, and after pediatric burn dressing changes</td>
<td>Identified a need for clearer communication between nurses and caregivers, the need for debriefing after a dressing change.</td>
</tr>
</tbody>
</table>
prevention department monitored rates of infections in the burn unit that were caused by multidrug-resistant organisms. The infections tracked were those caused by *Clostridium difficile*, methicillin-resistant *Staphylococcus aureus*, vancomycin-resistant enterococci, and *Acinetobacter baumannii*. This monitoring was also a way to ensure the safety of patients in relation to family presence.

**Results**

Family members who wished to be at the bedside for all dressing changes were encouraged to be there. Most, however, chose to observe only a few dressing changes. Families who appreciated the opportunity but declined to witness dressing changes were supported in that decision as well.

**Results of the Satisfaction Survey**

The burn unit had a mean response rate of approximately 23% to the surveys administered after discharge. The total number of responses was 35 for January 1, 2007, through February 28, 2009, and 37 for March 1, 2009, through December 31, 2011.

All metrics measured improved during the intervention period (Table 2 and Figure 1). The first goal of the intervention was to increase opportunities for communication and education. The family-presence group reported a higher level of satisfaction with the extent to which they were kept informed and involved in decision making during the hospitalization than did the control group. The second goal of the intervention was to improve discharge readiness. The family-presence group again indicated greater satisfaction with the instructions for care at home and the extent to which they felt ready for discharge. The third goal was to increase the satisfaction of patients and their families. The perception of staff members’ attitudes toward visitors and the overall rating again indicated greater satisfaction with the instructions for care at home and the extent to which they felt ready for discharge. The third goal was to increase the satisfaction of patients and their families. The perception of staff members’ attitudes toward visitors and the overall rating

### Table 2 Percent change after intervention

<table>
<thead>
<tr>
<th>Metric</th>
<th>Before intervention</th>
<th>After intervention</th>
<th>Change, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff attitudes toward visitors</td>
<td>87.5</td>
<td>95.0</td>
<td>7.5</td>
</tr>
<tr>
<td>Nurses kept you informed</td>
<td>90.0</td>
<td>96.5</td>
<td>6.5</td>
</tr>
<tr>
<td>Overall rating of nursing care</td>
<td>92.5</td>
<td>96.8</td>
<td>4.3</td>
</tr>
<tr>
<td>Included in decisions regarding treatment</td>
<td>87.1</td>
<td>91.0</td>
<td>3.9</td>
</tr>
<tr>
<td>Instructions for care at home</td>
<td>90.6</td>
<td>93.0</td>
<td>2.4</td>
</tr>
<tr>
<td>Extent felt ready for discharge</td>
<td>86.4</td>
<td>87.9</td>
<td>1.5</td>
</tr>
</tbody>
</table>

![Figure 1 Patients’ satisfaction scores before and after intervention.](image-url)
of nursing care both improved after implementation of family presence during dressing changes. No statistical analysis of the data was performed.

**Family Responses**

In feedback about family presence, a family member stated, “It makes me feel good to see the good care you give my husband.” A patient responded, “I feel more relaxed having my wife with me during dressing changes.” Another patient commented that it was “very kind and understanding to keep family present and involved.” To date, no family member has experienced an adverse event.

**Infection Rates**

The rate of infections caused by multidrug-resistant organisms did not increase after family presence was implemented. The unit’s baseline infection rate for 2008 was 13.5 per 1000 patient days. Since the implementation of family presence in March 2009, the overall rate has steadily decreased to 6.25 per 1000 patient days, through December 2011.

**Discussion**

Our results indicate that incorporation of family presence during burn dressing changes was successful (Figure 2). The success can be attributed to staff nurses’ taking the utmost care to prepare patients’ family members, provide education during dressing changes, and monitor the family members for tolerance throughout the experience. The feedback of patients and families is anecdotal, but it helps show the effectiveness of the intervention.

The patient satisfaction scores provide further evidence to support the success of the family presence initiative (Table 2 and Figure 1). The scores are indicative of the impact of family presence on the overall goals of improved communication, discharge readiness, and patient satisfaction. These data support previous evidence that additional education such as that received during dressing changes increases patient and family satisfaction and enhances the transition home.7 Readiness for discharge and instruction for care at home had the least improvement of all metrics, indicating a need to implement further programs to assist families in discharge preparation. These results most likely occurred because discharge is a multifactorial process, in which unique physical, emotional, and spiritual needs of patients and their families must be addressed.5,22,23 Addressing these needs involves collaboration among members of different disciplines to adequately prepare the family unit and cannot be fully accomplished with only a single intervention. Discharge preparation of burn patients is an area that needs further investigation.

Although the data on the rate of infection by multidrug-resistant organisms seems to indicate that family presence did not adversely affect the rate, the effect on infection rates cannot be definitively stated because the unit has implemented many infection control initiatives since 2009. The initiatives included hand-hygiene surveillance and implementation of care bundles to prevent ventilator-associated pneumonia and bloodstream infections associated with central catheters. However, ensuring strict adherence to hospital policies on personal protective equipment should minimize the impact of family presence on infection rates.

A noteworthy result of implementing family presence was the change in attitude among staff. Evidence of the change was reflected by the scores for the item on the satisfaction survey about staff members’ attitudes toward visitors; scores have improved dramatically since 2007. One nurse stated, “Developing a close connection with
our patients and their families is very important to us. Allowing family members to be present during dressing changes gives us another opportunity to do this.” Another nurse commented,

Having families present during dressings is a great opportunity to educate about burns and the healing process. For most people seeing the wounds brings about greater understanding. I think it helps them to really appreciate all the care that goes into helping heal their loved one’s wounds.

Staff members continue to embrace the PFCC core concept of participation.

Barriers
As indicated earlier, acceptance by staff members was a barrier encountered while implementing the practice change of family presence. Initially, staff personnel were informed about the literature that supports family presence during procedures. At the beginning of the project, no literature specific to family presence during dressing changes in an adult burn unit was available. Therefore, benefits of family presence had to be inferred from evidence gathered in other critical care specialties. This step required staff members to accept a process that had no direct evidence to support it. As with all quality improvement projects, identifying direct-care nurses to champion the initiative was vital to its overall success. The role of these champions is to lead by example and therefore garner acceptance from the rest of the staff. We recommend identifying such champions before the implementation of any quality improvement project.

Acceptance by physicians was an anticipated barrier; however, this barrier was not encountered. The unit’s medical director remained supportive throughout the process and was instrumental in obtaining physicians’ backing. Once the physicians were informed of the new process—that patients’ family members would be present during dressing changes and what to expect upon entering a patient’s room during a dressing change—we had no opposition to the change in practice.

Physical space within patients’ rooms was another barrier. Nurses worked with patients’ families to accommodate as many observers as possible, but restrictions had to be set on the basis of patient acuity, medical equipment, and number of staff required to complete the dressing change. The number of observers was determined on a case-by-case basis, but typically 1 to 3 observers were present.

Limitations
The number of patient satisfaction surveys returned is a limitation of the study. Of the approximately 313 surveys sent out from January 1, 2007, through December 31, 2011, only 72 were returned, for an overall return rate of 23%. This low return rate can be attributed to several factors. First, the surveys administered after discharge are identified by the unit from which the patient is discharged. Many burn patients are transferred to a step-down unit before they go home. Therefore, the surveys returned from these patients are reported back to the unit of discharge and are not included in the monthly report of the burn unit. Second, patients who are discharged to a rehabilitation or long-term care facility are not sent surveys. Third, 9% of surveys sent from the hospital were returned undeliverable because of variables such as change of address, high volume of indigent patients, and incomplete information provided during admission.

The survey sent was a standardized hospital survey and did not specifically address the goals of the intervention. In the future, using a family-patient survey tool specific for assessment of family presence would be beneficial. Such a tool would allow investigators to better quantify the impact of such a quality improvement project. Also, a statistical analysis of results would be beneficial in determining the significance of such an intervention.

Another limitation to this initiative was the occurrence of multiple PFCC-related practice changes after implementation of family presence. Changes included 24-hour visitation, unlocking of unit doors, and accommodations for overnight visitors. These changes could also have contributed to improved patient and family satisfaction.

Although feedback from families of patients previously treated in the burn unit was used in the decision making at the beginning of this quality improvement project, direct input from patients and patients’ families was not obtained during the planning phase. The inclusion of patients and their families in the planning phase is also part of the PFCC core concept of participation.24 Input from
patients and their family members should be used in the planning of any quality improvement project.

Nursing Implications
Our results support the need to further explore the implementation of family presence during procedures in all critical care areas. Our findings add to the body of knowledge that supports family presence. Although adult burn patients account for a rather small subsection of critical care, our information is easily translated to other specialty areas. The American Association of Critical-Care Nurses and the American College of Critical Care Medicine both recommend family presence during procedures.25,27 Health care organizations should integrate family presence into policy to align with this practice.4,17

Conclusion
Health care providers are responsible for treating not only the physical but also the emotional and spiritual needs of patients and patients’ family members. Using dressing changes as an opportunity to educate and include family members in care delivery aids in optimizing patients’ outcomes. Prominent misconceptions about the ability of patients’ families to handle being present for dressing changes were challenged with implementation of our quality improvement project.

Since family presence during dressing changes was implemented, positive feedback has been received from patients’ family members, patients, and staff. Satisfaction scores of patients in the burn unit improved after patients’ families were included in dressing changes. No increase in infection rates and no adverse events occurred. In conclusion, we recommend that health care professionals continue to investigate the incorporation of family presence during burn dressing changes. CCR

Unless we are making progress in our nursing every month, every week, take my word for it we are going back.

Florence Nightingale21

Now that you’ve read the article, create or contribute to an online discussion about this topic using eLetters. Just visit www.ccnonline.org and click “Submit a response” in either the full-text or PDF view of the article.

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References
