

Small patients, big obligations: Ending the copy-paste in paediatric wound care

We keep cutting adult cloth to fit children, then act surprised when the seams split. Paediatric wound care still leans on shrunken-down adult protocols and products, a habit that ignores the distinctive physiology, psychology and development of infants, children and adolescents. It is not merely suboptimal; it is ethically questionable. The result is avoidable pain, stalled healing and needless suffering in a vulnerable population (McNamara et al, 2020).

This is a call to end the copy-paste culture and build a paediatric-first approach, with materials, measures and guidance designed for children from the outset, not retrofitted after the fact. We need personalised strategies for prevention and treatment that honour the child's body, mind and family context.

We quote adult wound costs with confidence; in children, we mostly guess. What we do know points the same way: inadequate paediatric care lengthens admissions, multiplies procedures and weighs heavily on families – costs that ripple through health, education and society (Sen, 2021). Yet prevalence and economic burden in paediatrics remain poorly described, blunting policy, procurement and workforce planning. This is not only a data gap, it is also a moral gap. We cannot fund what we refuse to count, and we cannot improve what we do not measure.

The science already explains why copy-pasting fails. Paediatric skin is thinner, more fragile and behaves differently; immune maturation and thermoregulation are not adult-like; neonatal barrier function evolves postnatally, with preterm infants especially at risk (Lara-Corrales et al, 2020; Steen et al, 2020). Development shapes cooperation and pain expression, making procedure-related distress both common and, crucially, preventable. At the same time, modern paediatric care, such as ICU, oncology and long-term devices, creates distinct risk profiles for pressure injuries, non-healing surgical wounds and moisture-associated damage that do not map neatly onto adult trajectories. Pretending that adult rules apply unaltered is to ignore physiology and context in equal measure.

Measurement is where the ground is thinnest. Where are the validated paediatric wound assessment scales? Too often we reach for adult instruments, inviting misclassification,

poor product choice and slower healing. Pain assessment fares even worse: adult-centric tools miss the nuances of non-verbal or pre-verbal children, leading to undertreatment and compounding trauma. We need age-appropriate, culturally sensitive, rigorously validated measures for wound status, pain and risk, that are developed for children and stress-tested across settings (Santosa et al, 2020). Pressure injuries make the point starkly: prevalence varies widely and device-related injury is a recurring culprit; adult risk tools underperform in children because anatomy and pathophysiology differ. Research on paediatric risk, prevention and prediction is overdue, and consensus guidance must reflect paediatric evidence, not adult extrapolation.

Materials tell the same story. Most dressings, sizes and adhesives are engineered for adult bodies. Clinicians then “make them fit” small, dynamic, fragile integument, with predictable harm: poor conformability, pain on removal, medical-adhesive-related skin injury and iatrogenic damage. Reduced epidermal-dermal cohesion, pH differences, micronutrient variability and body composition amplify risk in children; device-related pressures compound it (Ciprandi et al, 2022). Commissioning child-appropriate materials is not a luxury; it is a patient-safety obligation. A ward stocked only with adult-scaled products sends, however unintentionally, the message that children were an afterthought.

Progress will come from many hands, not one miracle tool. Clinicians can retire the copy-paste reflex, choose the least-traumatic dressings and adhesives available, and tailor care to age, development, cognition and family context, while documenting the gaps they encounter so services can respond. Educators can teach the difference – paediatric skin physiology, prevention of adhesive injury, family-centred assent and consent – and assess competence using paediatric scenarios, not adult transpositions. Researchers can fill the void by validating paediatric wound, pain and risk tools across cultures and by co-designing trials of genuinely child-sized materials and protocols, with outcomes that matter to children and families. Policymakers and purchasers can procure for children and require routine reporting of paediatric prevalence, outcomes and costs to guide investment and

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accountability.

When we get the family right, we get the outcomes right. Elevate “family involvement” from courtesy to clinical strategy and embed it in protocols, metrics and budgets or we will keep shifting workload and worry from hospitals to households. Families are not bystanders in paediatric wound care, rather they are co-therapists, safety net and continuity of care in one. Prevention begins at home: teaching low-trauma skin care, early red-flag recognition and pain-minimising routines turns daily tasks into protective rituals. True partnership means assent/consent that respects the child and equips caregivers with clear plans, simple checklists and culturally attuned education they can actually use at 2 am. It also means designing dressings and devices that small hands can apply, scheduling that respects school and work, and using digital follow-up to cut unnecessary trips while preserving human contact. Measure what matters to families – comfort, sleep, disruption and confidence – not just wound area. Fund what families need, including training, travel and respite, or we simply rebadge hospital costs as household burdens. If care excludes the family, it is not paediatric care.

Let this be the turning point. We have named the harms, traced their origins and admitted that children are too often asked to endure care never designed for them. The path ahead is not a new gadget but a new stance: paediatric-first thinking as an ethical baseline, woven into how

we teach, lead, procure and practise. It means inviting families in as true partners, shaping care around childhood itself – its bodies, fears, hopes and futures – and refusing the false economy of “making do”. It means courage: to abandon habits that are comfortable but unfit, to demand solutions that honour dignity, and to be judged not by what we promised but by the suffering we prevented. History will not remember our explanations; it will remember the children who healed – or did not – under our watch. Build care that fits the child or accept that we chose convenience over conscience. ●

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