INTEGUMENTARY • GERONTOLOGY • NGN NCLEX 2026

Normal Aging Skin *vs.* Pathological Skin Changes

A clinical-judgment guide for separating expected age-related findings from red-flag pathology that requires escalation, intervention, or further workup in the older adult.

Topic: Skin Assessment in the Older Adult **Series:** Diane's NGN NCLEX 2026 Study Series

Test Plan: Health Promotion · Physiological Adaptation · Reduction of Risk

1 Definition & Overview

Why differentiating normal vs. pathological matters in geriatric care

Normal Age-Related Changes

Expected, gradual, symmetric changes that occur with chronological aging. They are **benign**, do not require treatment, and do not indicate disease.

Pathological Skin Changes

Findings that are new, asymmetric, rapidly evolving, painful, bleeding, or non-healing. They **require nursing assessment, documentation, and escalation**.

WHY THIS MATTERS ON NCLEX

Older adults have thinner, more fragile skin, slower healing, and altered immune response. Mistaking malignant melanoma for an age spot, or a stage 1 pressure injury for a "rash," can delay life-saving intervention. The NGN test plan emphasizes

RECOGNIZING CUES

and

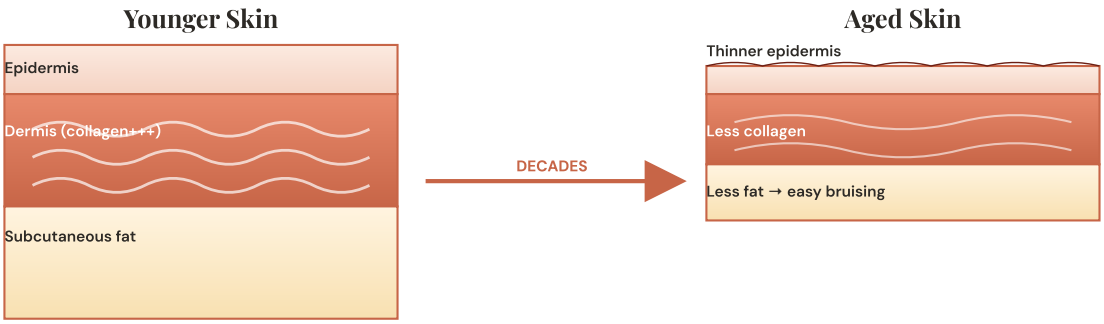
ANALYZING CUES

in the integumentary system as a clinical-judgment skill.

2

Pathophysiology of Aging Skin

The cellular changes behind every finding you'll assess



⏳ Decreased collagen & elastin → 📉 Thinner epidermis & flatter dermis → 💧 Decreased sebaceous & sweat glands →

🩸 Fragile capillaries & less SQ fat → ⚠️ Easy bruising, tearing, slow wound healing

Bottom line: Loss of collagen makes skin thin and inelastic → flattens the dermo-epidermal junction → less vascular support → **senile purpura**, skin tears, and pressure injuries from minor trauma. Decreased **melanocytes** cause graying and uneven pigmentation; decreased **vitamin D synthesis** increases osteoporosis risk; impaired **thermoregulation** raises hypothermia and heatstroke risk.

3

Signs & Symptoms — Normal vs. Pathological

The single most-tested distinction in older adult skin assessment

✓ EXPECTED

Normal Aging Findings

- ✓ **Wrinkles & sagging**
  Loss of elastin, gravity, sun exposure
- ✓ **Lentigines (age/liver spots)**
  Flat, brown, uniform color, sun-exposed areas
- ✓ **Seborrheic keratoses**
  "Stuck-on" waxy, tan-to-brown plaques — benign
- ✓ **Cherry angiomas**
  Small, smooth, bright red papules — benign
- ✓ **Skin tags (acrochordons)**
  Soft, flesh-colored, neck/axillae/groin
- ✓ **Senile purpura**
  Purple patches on forearms/dorsal hands from minor bumps
- ✓ **Xerosis (dry skin)**
  Decreased sebum; flaking, mild itch
- ✓ **Thickened, yellow nails**
  Slowed nail growth, longitudinal ridges
- ✓ **Graying & thinning hair**
  Decreased melanocytes, hair follicle loss
- ✓ **Decreased turgor**
  ⚠️ NOT a reliable hydration indicator in older adults — use sternum/forehead instead

🚨 RED FLAG

Pathological Findings

- 🚨 **New, asymmetric pigmented lesion**
  Possible melanoma — apply ABCDE rule
- 🚨 **Pearly papule with rolled border**
  Basal cell carcinoma — sun-exposed face, ears
- 🚨 **Scaly, ulcerated, non-healing lesion**
  Squamous cell carcinoma
- 🚨 **Non-blanchable erythema**
  Stage 1 pressure injury — over a bony prominence
- 🚨 **Cellulitis**
  Hot, red, swollen, painful — borders spreading; ± fever
- 🚨 **Herpes zoster (shingles)**
  Painful, unilateral, dermatomal vesicles
- 🚨 **Petechiae / large ecchymoses**
  Coag disorder, thrombocytopenia, abuse
- 🚨 **Cyanosis, jaundice, pallor**
  Hypoxia, liver disease, anemia
- 🚨 **Stasis dermatitis / venous ulcer**
  Brown lower-leg discoloration; medial malleolus ulcer
- 🚨 **Bruising in patterned/unusual areas**
  Inner thighs, upper arms, neck — assess for elder abuse

4

Skin Cancer Comparison

The three most common skin cancers in older adults — know the differences cold

Basal Cell Carcinoma (BCC)

MOST COMMON · RARELY METASTASIZES

- Pearly, waxy papule
- Rolled, raised border
- Central ulceration ("rodent ulcer")
- Telangiectasia (visible vessels)
- Sun-exposed: face, nose, ears
- Slow-growing; locally invasive

Squamous Cell Carcinoma (SCC)

2ND MOST COMMON · CAN METASTASIZE

- Rough, scaly, red plaque
- May ulcerate or crust
- May arise from actinic keratosis
- Sun-exposed: lips, ears, hands
- Faster growth than BCC
- Metastasis risk if untreated

Malignant Melanoma

MOST DEADLY · HIGHEST METASTATIC RISK

- Asymmetric pigmented lesion
- Variable colors (brown/black/red/white)
- Irregular borders
- Often arises from existing mole
- Can occur on non-sun-exposed skin
- Apply ABCDE rule below

🚨 ABCDE Rule for Melanoma Recognition

A	**B**	**C**	**D**	**E**
ASYMMETRY	**BORDER**	**COLOR**	**DIAMETER**	**EVOLVING**
Two halves do not match	Irregular, ragged, blurred	Varied; multiple shades	> 6 mm (pencil eraser)	Changing size, shape, color

5

Pressure Injury Staging (NPIAP)

High-yield NGN content — stage based on depth of tissue involvement

STAGE 1

Non-blanchable Erythema

Intact skin. Persistent redness that does **not** blanch (turn white) with pressure. Skin may be warmer or cooler than surrounding tissue.

STAGE 2

Partial Thickness

Exposed **dermis**. Shallow open ulcer with red-pink wound bed, OR an intact/ruptured serum-filled blister. No slough.

STAGE 3

Full Thickness

Subcutaneous fat visible. Bone, tendon, or muscle *not* exposed. Slough may be present but does not obscure depth. Undermining/tunneling possible.

STAGE 4

Deepest Full Thickness

Bone, tendon, or muscle exposed. Slough or eschar may be present. Often includes undermining, tunneling, and risk of osteomyelitis.

UNSTAGEABLE

Obscured Depth

Full-thickness loss with base covered by **slough or eschar**. Cannot stage until base is visible. Stable (dry, intact) heel eschar — do **not** debride.

DEEP TISSUE INJURY

Suspected Deep Tissue

Persistent **non-blanchable deep red, purple, or maroon** intact skin, OR a blood-filled blister. May rapidly evolve to Stage 3 or 4.

6 Priority Nursing Interventions

ABCs of skin: Assess → Prevent → Escalate

ASSESS

- Head-to-toe skin assessment on admission & every shift
- Inspect bony prominences (sacrum, heels, hips, occiput, elbows)
- Note color, moisture, temperature, turgor, integrity
- Document size, depth, drainage, odor, surrounding skin
- Check skin folds (under breast, abdomen, perineum)
- Use **Braden Scale** on admission & per facility policy
- Photograph wounds per facility protocol

PREVENT

- **Reposition every 2 hours** in bed; every 1 hr in chair
- Use pressure-redistribution surfaces (foam, air, gel)
- Keep **HOB ≤ 30°** to prevent shear
- Float heels off bed with pillows
- Use lift sheets — never drag (avoid friction/shear)
- Clean & dry skin promptly after incontinence; barrier cream
- Optimize nutrition: **protein, vitamin C, zinc**, hydration
- Moisturize dry skin; avoid hot water & harsh soaps

ESCALATE

- New, asymmetric, or evolving pigmented lesion
- Non-healing wound > 2 weeks
- Spreading erythema, warmth, purulence, fever (cellulitis)
- Unilateral dermatomal vesicles (zoster)
- Stage 3, 4, unstageable, or deep tissue injury
- Sudden cyanosis, mottling, jaundice
- Bruising in suspicious patterns/locations
- Notify HCP & consult wound care/dermatology

Braden Scale — Pressure Injury Risk

Six subscales rated 1–4 (or 1–3 for friction/shear). Total: 6–23. **Lower score = higher risk.**

Sensory	Moisture	Activity	Mobility	Nutrition	Friction
Perception	Skin exposure	Physical activity	Position change	Intake pattern	& Shear

≤ 18 = AT RISK · ≤15 moderate · ≤12 high · ≤9 very high

7 Pharmacology & Topical Treatments

Common medications for older-adult skin conditions

DRUG / CLASS	USE	KEY SIDE EFFECTS	NURSING CONSIDERATIONS
Topical Corticosteroids hydrocortisone, triamcinolone	Eczema, dermatitis, pruritus	Skin thinning, striae, telangiectasia, systemic absorption	Thin layer, short courses; avoid face/skin folds; do **not** occlude unless ordered
Emollients / Moisturizers petrolatum, urea cream	Xerosis (dry skin)	Generally well tolerated	Apply to **damp** skin within 3 min of bathing; pat dry, don't rub
Acyclovir / Valacyclovir antiviral	Herpes zoster (shingles)	Nephrotoxicity, headache, GI upset	Start within **72 hr** of rash onset; encourage fluids; isolate from immunocompromised & pregnant contacts
Cephalexin / Clindamycin antibiotic	Cellulitis	GI upset, allergy, C. difficile	Mark borders of erythema with marker; reassess for spread & fever; complete full course
Silver Sulfadiazine topical antimicrobial	Burns, infected wounds	Leukopenia, allergy in sulfa-sensitive	Avoid in sulfa allergy; apply 1/16-inch layer with sterile glove
Mupirocin (Bactroban) topical antibiotic	Impetigo, MRSA decolonization	Local burning, itching	Apply 3× daily; cover with gauze if needed
Zinc Oxide / Barrier Creams	Incontinence-associated dermatitis, prevention	Minimal	Apply after each cleansing; do **not** scrub off — layer fresh on top

DRUG / CLASS	USE	KEY SIDE EFFECTS	NURSING CONSIDERATIONS
5-Fluorouracil (topical) antineoplastic	Actinic keratosis, superficial BCC	Severe local inflammation, photosensitivity	Wear gloves to apply; sun protection; expect redness — do not stop unless ordered

8 NCLEX Test Traps ⚠

Common confusion points the test exploits

✗ WRONG THINKING

"Bruising on the forearms means abuse."

Senile purpura is a normal age-related finding from fragile capillaries on sun-damaged forearms.

✓ CORRECT THINKING

Patterned bruising or bruises in unusual locations (inner thighs, upper arms, neck, in shapes like belt or hand) — that is the abuse red flag.

✗ WRONG THINKING

"Tenting on the back of the hand means dehydration."

Decreased turgor is a normal aging change; back-of-hand turgor is unreliable in older adults.

✓ CORRECT THINKING

Assess turgor on the **sternum or forehead**. Better hydration cues: mucous membranes, urine output, BP, weight changes.

✗ WRONG THINKING

"All blistering is Stage 2 pressure injury."

A blood-filled blister is a deep tissue injury, not Stage 2.

✓ CORRECT THINKING

Serum-filled = Stage 2. **Blood-filled** = Deep Tissue Injury. **Slough/eschar covering wound** = Unstageable.

✗ WRONG THINKING

"Debride dry, stable eschar on the heel."

This removes the body's natural cover and risks deeper injury.

✓ CORRECT THINKING

Leave stable, dry, intact heel eschar in place. Float heels off bed; assess daily; debride only if it becomes unstable, fluctuant, or infected.

✗ WRONG THINKING

"That waxy, stuck-on brown patch is melanoma."

That description fits seborrheic keratosis — a benign aging change.

✓ CORRECT THINKING

Apply ABCDE. Melanoma is asymmetric, irregular border, varied color, >6 mm, evolving. Seborrheic keratoses are uniform and "stuck-on."

✗ WRONG THINKING

"Higher Braden score = higher risk."

This is backwards.

✓ CORRECT THINKING

Lower Braden = higher risk. ≤18 = at risk. The lower the number, the more you must intervene with prevention.

9 Patient & Family Education

What to teach the older adult and caregivers

☀️ Sun Protection

- ✓ SPF 30+ broad spectrum daily, even cloudy days
- ✓ Wide-brim hat, long sleeves, UV-blocking sunglasses
- ✓ Avoid peak sun: 10 AM–4 PM
- ✓ Reapply sunscreen every 2 hr or after sweating

💧 Skin Care Basics

- ✓ Use lukewarm (not hot) water; limit baths to 5–10 min
- ✓ Use mild, fragrance-free, pH-balanced cleansers
- ✓ Pat dry — do not rub
- ✓ Moisturize within 3 min of bathing while skin is damp

🔍 Self-Skin Examination

- ✓ Monthly check head-to-toe; use a mirror or partner
- ✓ Watch for new, changing, bleeding, or non-healing lesions
- ✓ Apply **ABCDE** to all moles
- ✓ Report any changes to HCP promptly

🩹 Pressure Injury Prevention

- ✓ Reposition every 2 hr in bed; shift weight every 15 min in chair
- ✓ Keep skin clean, dry, and moisturized
- ✓ Adequate hydration & protein-rich diet
- ✓ Wear loose, soft clothing; avoid wrinkled bedding

🥗 Nutrition for Skin Health

- ✓ Adequate protein (1.0–1.5 g/kg if at risk)
- ✓ Vitamin C, zinc, vitamin A for wound healing
- ✓ Vitamin D supplement if limited sun exposure
- ✓ Hydration: ~1.5–2 L/day unless restricted

💉 Shingles Prevention

- ✓ Recombinant zoster vaccine (Shingrix) recommended for adults ≥50
- ✓ Two doses, 2–6 months apart
- ✓ Even if you've had shingles or chickenpox before
- ✓ Report rash with pain promptly — antivirals work best within 72 hr

10

Memory Boosters & Mnemonics

Quick associations to lock in for exam day

Melanoma Recognition

A B C D E

- **A** Asymmetry
- **B** Border irregular
- **C** Color varied
- **D** Diameter > 6 mm
- **E** Evolving

Pressure Injury Risk Factors

P R E S S U R E

- **P** Paralysis / immobility
- **R** Restricted activity
- **E** Edema
- **S** Sensory loss
- **S** Shear & friction
- **U** Unconsciousness / incontinence
- **R** Reduced nutrition
- **E** Elderly

Skin Cancer Quick Cue

B · S · M

- **B** BCC = "Basal" = "Border rolled, pearly"
- **S** SCC = "Scaly" "Scab won't heal"
- **M** Melanoma = "Most deadly" — apply ABCDE

Pressure Injury Stages

1 → 2 → 3 → 4

- **1** Intact, red, won't blanch
- **2** Through dermis (blister/shallow)
- **3** Three layers — see Subq fat
- **4** Four = Bone/tendon/muscle

Cellulitis Red Flags

H O T

- **H** Hot to touch
- **O** Oedematous (swollen) & spreading
- **T** Tender, red, ± fever

Wound Healing Nutrients

P · C · Z · A

- **P** Protein — building blocks
- **C** Vitamin C — collagen synthesis
- **Z** Zinc — cell regeneration
- **A** Vitamin A — epithelialization

11

NCJMM Clinical Judgment Scenario

Apply the 6-step Clinical Judgment Measurement Model

Six-Step Clinical Judgment Walkthrough

Recognize → Analyze → Prioritize → Generate → Take Action → Evaluate

PATIENT SCENARIO

An 82-year-old female is admitted from a long-term care facility for confusion. On the head-to-toe assessment, the nurse notes (1) flat, brown, uniform spots on the dorsal hands, (2) several "stuck-on" waxy tan plaques on the back, (3) a 2 cm asymmetric lesion on the left calf with irregular borders and three colors that the family says "wasn't there last month," (4) a 3 cm area of non-blanchable erythema over the sacrum, and (5) purple bruising on both forearms. Vital signs: T 99.0°F, BP 142/86, HR 92, RR 18, SpO_2 95%.

1

RECOGNIZE CUES

Pertinent: asymmetric calf lesion, sacral non-blanchable redness. **Expected/normal:** lentigines, seborrheic keratoses, senile purpura.

2

ANALYZE CUES

Calf lesion meets ABCDE criteria → **possible melanoma**. Sacral redness over a bony prominence in an older immobile patient → **Stage 1 pressure injury**.

3

PRIORITIZE HYPOTHESES

#1 Stage 1 pressure injury (immediate prevention prevents progression). **#2 Suspected melanoma** (urgent dermatology workup). Other findings benign.

4

GENERATE SOLUTIONS

Reposition q2h; offload sacrum; pressure-redistribution surface; barrier cream if incontinent; Braden Scale; document & photograph calf lesion; notify HCP for derm consult.

5

TAKE ACTION

Implement turning schedule and float heels; complete Braden assessment; place pressure-redistribution mattress; document lesion size, location, ABCDE features; notify HCP and request dermatology referral.

6

EVALUATE OUTCOMES

Sacral redness resolves within 24–72 hr without progression; turning log complete; dermatology workup scheduled; family verbalizes understanding of skin checks & sun protection.

Diane's NGN NCLEX 2026 Study Series

Normal vs. Pathological Skin Changes in the Older Adult · Integumentary · Gerontology
Standard NCLEX 2026 nursing references & NPIAP pressure injury staging guidelines.
Print to PDF in color · Save with background graphics enabled