1. The nurse is examining a 10-month-old boy who was born 10 weeks early. Which finding is cause for concern?
   A) The child has doubled his birth weight.
   B) The child exhibits plantar grasp reflex.
   C) The child's head circumference is 19.5 inches.
   D) No primary teeth have erupted yet.
   Ans: C
   Feedback: The child's head size is large for his adjusted age (7.5 months), which would be cause for concern. Birth weight doubles by about 4 months of age. Plantar grasp reflex does not disappear until 9 months adjusted age. Primary teeth may not erupt until 8 months adjusted age.

2. The nurse is teaching a new mother about the drastic growth and developmental changes her infant will experience in the first year of life. Which statement describes a developmental milestone occurring in infancy?
   A) By 6 months of age the infant's brain weighs half that of the adult brain; at age 12 months, the brain weighs 2.5 times what it did at birth.
   B) Most infants triple their birthweight by 4 to 6 months of age and quadruple their birthweight by the time they are 1 year old.
   C) The head circumference increases rapidly during the first 6 months: the average increase is about 1 inch per month.
   D) The heart triples in size over the first year of life; the average pulse rate decreases from 120 to 140 in the newborn to about 100 in the 1-year-old.
   Ans: A
   Feedback: By 6 months of age the infant's brain weighs half that of the adult brain; at age 12 months, the brain weighs 2.5 times what it did at birth. Most infants double their birthweight by 4 to 6 months of age and triple their birthweight by the time they are 1 year old. The head circumference increases rapidly during the first 6 months: the average increase is about 0.6 inch (1.5 cm) per month. The heart doubles in size over the first year of life. As the cardiovascular system matures, the average pulse rate decreases from 120 to 140 in the newborn to about 100 in the 1-year-old.
3. The nurse is assessing the respiratory system of a newborn. Which anatomic differences place the infant at risk for respiratory compromise? Select all that apply.
A) The nasal passages are narrower.
B) The trachea and chest wall are less compliant.
C) The bronchi and bronchioles are shorter and wider.
D) The larynx is more funnel shaped.
E) The tongue is smaller.
F) There are significantly fewer alveoli.
Ans: A, D, F

Feedback:
In comparison with the adult, in the infant, the nasal passages are narrower, the trachea and chest wall are more compliant, the bronchi and bronchioles are shorter and narrower, the larynx is more funnel shaped, the tongue is larger, and there are significantly fewer alveoli. These anatomic differences place the infant at higher risk for respiratory compromise. The respiratory system does not reach adult levels of maturity until about 7 years of age.

4. A new mother shows the nurse that her baby grasps her finger when she touches the baby's palm. How might the nurse respond to this information?
A) 'This is a primitive reflex known as the plantar grasp.'
B) 'This is a primitive reflex known as the palmar grasp.'
C) 'This is a protective reflex known as rooting.'
D) 'This is a protective reflex known as the Moro reflex.'
Ans: B

Feedback:
Primitive reflexes are subcortical and involve a whole-body response. Selected primitive reflexes present at birth include Moro, root, suck, asymmetric tonic neck, plantar and palmar grasp, step, and Babinski. During the palmar grasp, the infant reflexively grasps when the palm is touched. The plantar grasp occurs when the infant reflexively grasps with the bottom of the foot when pressure is applied to the plantar surface. The root reflex occurs when the infant's cheek is stroked and the infant turns to that side, searching with mouth. The Moro reflex is displayed when with sudden extension of the head, the arms abduct and move upward and the hands form a "C."
5. Which reflex, if found in a 4-month-old infant, would cause the nurse to be concerned?  
   A) Plantar grasp  
   B) Step  
   C) Babinski  
   D) Neck righting  
   Ans: B  
   Feedback:  
   Appropriate appearance and disappearance of primitive reflexes, along with the development of protective reflexes, indicates a healthy neurologic system. The step reflex is a primitive reflex that appears at birth and disappears at 4 to 8 weeks of age. The plantar grasp reflex is a primitive reflex that appears at birth and disappears at about the age of 9 months. The Babinski reflex is a primitive reflex that appears at birth and disappears around the age of 12 months. The neck righting reflex is a protective reflex that appears around the age of 4 to 6 months and persists.

Origin: Chapter 3, 5  

6. A new mother expresses concern to the nurse that her baby is crying and grunting when passing stool. What is the nurse's best response to this observation?  
   A) 'This is normal behavior for infants unless the stool passed is hard and dry.'  
   B) 'This is normal behavior for infants due to the immaturity of the gastrointestinal system.'  
   C) 'This indicates a blockage in the intestine and must be reported to the physician.'  
   D) 'This is normal behavior for infants unless the stool passed is black or green.'  
   Ans: A  
   Feedback:  
   Due to the immaturity of the gastrointestinal system, newborns and young infants often grunt, strain, or cry while attempting to have a bowel movement. This is not of concern unless the stool is hard and dry. Stool color and texture may change depending on the foods that the infant is ingesting. Iron supplements may cause the stool to appear black or very dark green.
7. The neonatal nurse assesses newborns for iron-deficiency anemia. Which newborn is at highest risk for this disorder?
   A) A postterm newborn
   B) A term newborn with jaundice
   C) A newborn born to a diabetic mother
   D) A premature newborn
   Ans: D
   Feedback:
   Maternal iron stores are transferred to the fetus throughout the last trimester of pregnancy. Infants born prematurely miss all or at least a portion of this iron store transfer, placing them at increased risk for iron-deficiency anemia compared with term infants. An infant having jaundice, having been born to a mother with diabetes, or have been born postterm does not significantly place the infant at risk for iron-deficiency anemia.

8. The nurse caring for newborns knows that infants exhibit phenomenal increases in their gross motor skills over the first 12 months of life. Which statements accurately describe the typical infant’s achievement of these milestones? Select all answers that apply.
   A) At 1 month the infant lifts and turns the head to the side in the prone position.
   B) At 2 months the infant rolls from supine to prone to back again.
   C) At 6 months the infant pulls to stand up.
   D) At 7 months the infant sits alone with some use of hands for support.
   E) At 9 months the infant crawls with the abdomen off the floor.
   F) At 12 months the infant walks independently.
   Ans: A, D, E, F
   Feedback:
   At 1 month the infant lifts and turns the head to the side in the prone position. At 7 months the infant sits alone with some use of hands for support. At 9 months the infant crawls with the abdomen off the floor. At 12 months the infant walks independently. At 4 months the infant lifts the head and looks around. At 10 months the infant pulls to stand up.
9. The nurse is teaching a new mother about the development of sensory skills in her newborn. What would alert the mother to a sensory deficit in her child?
   A) The newborn's eyes wander and occasionally are crossed.
   B) The newborn does not respond to a loud noise.
   C) The newborn's eyes focus on near objects.
   D) The newborn becomes more alert with stroking when drowsy.
   Ans: B

Feedback:
Though hearing should be fully developed at birth, the other senses continue to develop as the infant matures. The newborn should respond to noises. Sight, smell, taste, and touch all continue to develop after birth. The newborn's eyes wander and occasionally cross, and the newborn is nearsighted, preferring to view objects at a distance of 8 to 15 inches. Holding, stroking, rocking, and cuddling calm infants when they are upset and make them more alert when they are drowsy.

10. The nurse is assessing a 4-month-old boy during a scheduled visit. Which findings might suggest a developmental problem?
   A) The child does not babble.
   B) The child does not vocally respond to voices.
   C) The child never squeals or yells.
   D) The child does not say dada or mama.
   Ans: B

Feedback:
The fact that the child does not vocally respond to voices might suggest a developmental problem. At 4 to 5 months of age most children are making simple vowel sounds, laughing aloud, doing raspberries, and vocalizing in response to voices. The child is too young to babble, squeal, yell, or say dada or mama.
11. The nurse observes an infant interacting with his parents. What are normal social behavioral developments for this age group? Select all that apply.
   A) Around 5 months the infant may develop stranger anxiety.
   B) Around 2 months the infant exhibits a first real smile.
   C) Around 3 months the infant smiles widely and gurgles when interacting with the caregiver.
   D) Around 3 months the infant will mimic the parent’s facial movements, such as sticking out the tongue.
   E) Around 3 to 6 months of age the infant may enjoy socially interactive games such as patty-cake and peek-a-boo.
   F) Separation anxiety may also start in the last few months of infancy.
   Ans: B, C, D, F
   Feedback:
   The infant exhibits a first real smile at age 2 months. By about 3 months of age the infant will start an interaction with a caregiver by smiling widely and possibly gurgling. The 3- to 4-month-old will also mimic the parent's facial movements, such as widening the eyes and sticking out the tongue. Separation anxiety may also start in the last few months of infancy. Around the age of 8 months the infant may develop stranger anxiety. At 6 to 8 months of age the infant may enjoy socially interactive games such as patty-cake and peek-a-boo.

12. The nurse is performing a health assessment of a 3-month-old African-American boy. For what condition should this infant be monitored based on his race?
   A) Jaundice
   B) Iron deficiency
   C) Lactose intolerance
   D) Gastroesophageal reflux disease (GERD)
   Ans: C
   Feedback:
   Many dietary practices are affected by culture, both in the types of food eaten and in the approach to progression of infant feeding. Some ethnic groups tend to be lactose intolerant (particularly blacks, Native Americans, and Asians); therefore, alternative sources of calcium must be offered. Jaundice, iron deficiency, and GERD are not seen at a significantly higher rate in African American infants.
13. The nurse is promoting a healthy diet to guide a mother when feeding her 2-week-old girl. Which is the most effective anticipatory guidance?
   A) Substituting cow's milk if breast milk is not available
   B) Advocating iron supplements with bottle-feeding
   C) Advising fluid intake per feeding of 5 or 6 ounces
   D) Discouraging the addition of fruit juice to the diet
   Ans: D

   Feedback:
   Discouraging the addition of fruit juice to the child's diet is the most effective anticipatory guidance. Fruit juice can displace important nutrients from breast milk or formula. Cow's milk is likely to result in an allergic reaction. If breast milk is not available, infant formula may be substituted. Advising fluid intake per feeding of 5 or 6 ounces is too much for this neonate, but is typical for an infant 4 to 6 months of age. Advocating iron supplements with bottle-feeding is unnecessary so long as the formula is fortified with iron.

14. The nurse is teaching a new mother the proper techniques for breastfeeding her newborn. Which is a recommended guideline that should be implemented?
   A) Wash the hands and breasts thoroughly prior to breastfeeding.
   B) Stroke the nipple against the baby's chin to stimulate wide opening of the baby's mouth.
   C) Bring the baby's wide-open mouth to the breast to form a seal around all of the nipple and areola.
   D) When finished the mother can break the suction by firmly pulling the baby's mouth away from the nipple.
   Ans: C

   Feedback:
   Before each breastfeeding session, mothers should wash their hands, but it is not necessary to wash the breast in most cases. The mother should then stroke the nipple against the baby's cheek to stimulate opening of the mouth and bring the baby's wide-open mouth to the breast to form a seal around all of the nipple and areola. When the infant is finished feeding, the mother can break the suction by inserting her finger into the baby's mouth.
15. The nurse is providing discharge teaching regarding formula preparation for a new mother. Which guideline would the nurse include in the teaching plan?
A) Always wash bottles and nipples in hot soapy water and rinse well; do not wash them in the dishwasher.
B) Store tightly covered ready-to-feed formula can after opening in refrigerator for up to 24 hours.
C) Warm bottle of formula by placing bottle in a container of hot water, or microwaving formula.
D) Do not add cereal to the formula in the bottle or sweeten the formula with honey.
Ans: D

Feedback:
Proper formula preparation includes the following: wash nipples and bottles in hot soapy water and rinse well or run nipples and bottles through the dishwasher; store tightly covered ready-to-feed formula can after opening in refrigerator for up to 48 hours; after mixing concentrate or powdered formula, store tightly covered in refrigerator for up to 48 hours; do not reheat and reuse partially used bottles; throw away the unused portion after each feeding; do not add cereal to the formula in the bottle; do not sweeten formula with honey; warm formula by placing bottle in a container of hot water; and do not microwave formula.

16. The nurse is caring for a 4-week-old girl and her mother. Which is the most appropriate subject for anticipatory guidance?
A) Promoting the digestibility of breast milk
B) Telling how and when to introduce rice cereal
C) Describing root reflex and latching on
D) Advising how to choose a good formula
Ans: B

Feedback:
Telling the mother how to introduce rice cereal is the most appropriate subject for anticipatory guidance. Since this mother is already breast- or bottle-feeding her baby, educating her about these subjects would not inform her about what to expect in the next phase of development.
17. The nurse is providing anticipatory guidance to a mother of a 5-month-old boy about introducing solid foods. Which statement by the mother indicates that effective teaching has occurred?
A) "I'll start with baby oatmeal cereal mixed with low-fat milk."
B) "The cereal should be a fairly thin consistency at first."
C) "I can puree the meat that we are eating to give to my baby."
D) "Once he gets used to the cereal, then we'll try giving him a cup."
Ans: B
Feedback:
Iron-fortified rice cereal mixed with a small amount of formula or breast milk to a fairly thin consistency is typically the first solid food used. As the infant gets older, a thicker consistency is appropriate. Strained, pureed, or mashed meats may be introduced at 10 to 12 months of age. A cup is typically introduced at 6 to 8 months of age regardless of what or how much solid food is being consumed.

18. The nurse is providing anticipatory guidance to the mother of a 9-month-old girl during a well-baby visit. Which topic would be most appropriate?
A) Advising how to create a toddler-safe home
B) Warning about small objects left on the floor
C) Cautioning about putting the baby in a walker
D) Telling about safety procedures during baths
Ans: A
Feedback:
The most appropriate topic for this mother would be advising her on how to create a toddler-safe home. The child will very soon be pulling herself up to standing and cruising the house. This will give her access to areas yet unexplored. Warning about small objects left on the floor, telling about safety procedures during baths, and cautioning about using baby walkers would no longer be anticipatory guidance as the child has passed these stages.
19. The nurse in a community clinic is caring for a 6-month-old boy and his mother. Which intervention is priority to promote adequate growth?
A) Monitoring the child's weight and height
B) Encouraging a more frequent feeding schedule
C) Assessing the child's current feeding pattern
D) Recommending higher-calorie solid foods
Ans: A

Feedback:
Monitoring the child's weight and height is the priority intervention to promote adequate growth. Encouraging a more frequent feeding schedule, assessing the child's current feeding pattern, and recommending higher-calorie solid foods are interventions when the nursing diagnosis is that nutrition level does not meet body requirements.

20. The nurse is caring for a 7-month-old girl during a well-child visit. Which intervention is most appropriate for this child?
A) Discussing the type of sippy cup to use
B) Advising about increased caloric needs
C) Explaining how to prepare table meats
D) Describing the tongue extrusion reflex
Ans: A

Feedback:
The cup may be introduced at 6 to 8 months of age. Old-fashioned sippy cups are preferred compared to the new style. The nurse would not advise about increased caloric needs as caloric needs drop at this age. Transition to table meat will not take place until age 10 to 12 months. Tongue extrusion reflex has disappeared at age 4 to 6 months.

21. The nurse is assessing a 12-month-old boy with an English-speaking father and a Spanish-speaking mother. The boy does not say mama or dada yet. What is the priority intervention?
A) Performing a developmental evaluation of the child
B) Encouraging the parents to speak English to the child
C) Asking the mother if the child uses Spanish words
D) Referring the child to a developmental specialist
Ans: C

Feedback:
Infants in bilingual families may use some words from each language. Therefore, the priority intervention in this situation would be to ask the mother if the child uses Spanish words. There is not enough evidence to warrant performing a developmental evaluation or referring the child to a developmental specialist. Encouraging the parents to speak English to the child is unnecessary if the child is progressing with Spanish first.
22. A 6-month-old girl weighs 14.7 pounds during a scheduled check-up. Her birth weight was 8 pounds. What is the priority nursing intervention?
   A) Talking about solid food consumption  
   B) Discouraging daily fruit juice intake  
   C) Increasing the number of breastfeedings  
   D) Discussing the child's feeding patterns  
   Ans: D  
   Feedback:  
   Assessing the current feeding pattern and daily intake is the priority intervention. Talking about solid food consumption may not be appropriate for this child yet. Discouraging daily fruit juice intake or increasing the number of breastfeedings may not be necessary until the situation is assessed.

23. The nurse is educating a first-time mother who has a 1-week-old boy. Which is the most accurate anticipatory guidance?
   A) Describing the effect of neonatal teeth on breastfeeding  
   B) Explaining that the stomach holds less than 1 ounce  
   C) Informing that fontanels will close by 6 months  
   D) Telling that the step reflex persists until the child walks  
   Ans: B  
   Feedback:  
   Explaining that the child's stomach holds less than 1 ounce gives the mother a reason for frequent, small feedings and is the most helpful and accurate anticipatory guidance. Telling that the step reflex persists until the child walks and informing that fontanels will close by 6 months are inaccurate. The step reflex disappears at about 2 months and fontanels close between 12 and 18 months. Neonatal teeth are highly unusual and need no explanation unless they occur.
24. A mother is concerned about her infant's spitting up. Which suggestion would be most appropriate?

A) "Put the infant in an infant seat after eating."
B) "Limit burping to once during a feeding."
C) "Feed the same amount but space out the feedings."
D) "Keep the baby sitting up for about 30 minutes afterward."

Ans: D

Feedback:
Keeping the baby upright for 30 minutes after the feeding, burping the baby at least two or three times during feedings, and feeding smaller amounts on a more frequent basis may help to decrease spitting up. Positioning the infant in an infant seat compresses the stomach and is not recommended.

25. The nurse is providing anticipatory guidance to a mother to help promote healthy sleep for her 3-week-old baby. Which recommended guideline might be included in the teaching plan?

A) Place the baby on a soft mattress with a firm, flat pillow for the head.
B) Place the head of the bed near the window to provide fresh air, weather permitting.
C) Place the baby on his or her back when sleeping.
D) If the baby sleeps through the night, wake him or her up for the night feeding.

Ans: C

Feedback:
Sudden infant death syndrome (SIDS) has been associated with prone positioning of newborns and infants, so the infant should be placed to sleep on the back. The baby should sleep on a firm mattress without pillows or comforters. The baby's bed should be placed away from air conditioner vents, open windows, and open heaters. By 4 months of age night waking may occur, but the infant should be capable of sleeping through the night and does not require a night feeding.
26. The nurse is counseling the mother of a newborn who is concerned about her baby's constant crying. What teaching would be appropriate for this mother?
   A) Carrying the baby may increase the length of crying.
   B) Reducing stimulation may decrease the length of crying.
   C) Using vibration, white noise, or swaddling may increase crying.
   D) Using a swing or car ride may increase the incidence of crying episodes.
   Ans: B

Feedback:
Prolonged crying leads to increased stress among caregivers. Reducing stimulation may decrease the length of crying, and carrying the infant more may be helpful. Some infants respond to the motion of an infant swing or a car ride. Vibration, white noise, or swaddling may also help to decrease fussing in some infants. Parents should try one intervention at a time, taking care not to stimulate the infant excessively in the process of searching for solutions.

27. The parent of a 6-month-old infant asks the nurse for advice about his son's thumb sucking. What would be the nurse's best response to this parent?
   A) 'Thumb sucking is a healthy self-comforting activity.'
   B) 'Thumb sucking leads to the need for orthodontic braces.'
   C) 'Caregivers should pay special attention to the thumb sucking to stop it.'
   D) 'Thumb sucking should be replaced with the use of a pacifier.'
   Ans: A

Feedback:
Thumb sucking is a healthy self-comforting activity. Infants who suck their thumbs or pacifiers often are better able to soothe themselves than those who do not. Studies have not shown that sucking either thumbs or pacifiers leads to the need for orthodontic braces unless the sucking continues well beyond the early school-age period. The infant who has become attached to thumb sucking should not have additional attention drawn to the issue, as that may prolong thumb sucking. Pacifiers should not be used to replace thumb sucking as this habit will also need to be discouraged as the child grows.
28. At which age would the nurse expect to find the beginning of object permanence?
   A) 1 month  
   B) 6 months  
   C) 9 months  
   D) 12 months  
   Ans: B
   **Feedback:**
   Object permanence begins to develop between 4 and 7 months of age and is solidified by approximately age 8 months. By age 12 months, the infant knows he or she is separate from the parent or caregiver.

29. The nurse is assessing the infants in the nursery for the six stages of consciousness. The nurse becomes concerned when assessing which infants? Select all that apply.
   A) An infant rapidly moves from deep sleep to crying  
   B) An infant moves from active alert state to drowsiness  
   C) An infant progresses slowly from deep sleep to light sleep  
   D) An infant frequently skips the quiet alert state during the six stages of consciousness  
   E) An infant ends the stages of consciousness with crying  
   Ans: A, B, D
   **Feedback:**
   The nurse becomes concerned when if the infant does not move slowly through six stages of consciousness, which begins with deep sleep. The infant should then progress as follows: light sleep, drowsiness, quiet alert state, active alert state, and finally crying. States are not normally skipped.
Origin: Chapter 3, 30

30. A new mother tells the nurse that she is having difficulty breastfeeding her baby. When observing the mother, which actions prompt the nurse to provide teaching about proper breastfeeding techniques? Select all that apply.
A) The mother carefully washes her breasts prior to feeding the infant.
B) The mother feeds the infant every hour.
C) The mother supplements feedings with water.
D) The mother holds her breast in the "C" position.
E) The mother strokes the nipple against the infant's face.

Ans: A, B, C

Feedback:
The mother should wash her hands prior to breastfeeding the infant. There is no need to wash the breasts in most circumstances. The best time to feed the infant is on demand rather than hourly, and there is no need to supplement breastfeeding with water. The "C" position and stroking the nipple against the infant's face promote effective breastfeeding.

Origin: Chapter 3, 31

31. The nurse is assessing the developmental milestones of an infant. The infant was born 8 weeks ago and was 4 weeks premature. The nurse anticipates that the infant will be meeting milestones for what age of child? Record your answer in weeks.

Ans: 4

Feedback:
To determine adjusted age, subtract the number of weeks that the infant was premature (4 weeks) from the infant's chronological age (8 weeks).