

Detailed Answer Key N433 Exam 2 Practice Questions

1. A new mother, when asked by a nurse, explains that her 4-month-old infant has been nursing regularly every 3 to 4 hours but seems satisfied. However, the mother recently introduced solid food in the form of unbuttered popcorn to the baby as a supplement, to "get her used to eating solid food." She felt that the popcorn would be safe because it is soft on the baby's gums. What should be the priority nursing diagnosis in this situation?

A. Risk for aspiration

Rationale: Children under about 5 years should not be offered popcorn or peanuts because of the danger of aspiration. This should be the primary nursing diagnosis because aspiration is the greatest danger to the infant in this scenario.

B. Imbalanced nutrition, less than body requirements

Rationale: Because the infant is receiving all the nutrition she needs from breastfeeding and because unbuttered popcorn is not a high-calorie food, imbalanced nutrition is not really a concern here.

C. Readiness for enhanced nutrition

Rationale: There is not a strong indication at this point that the infant is ready for enhanced nutrition, as the breast milk provides all of the nutrients she needs and as she appears to be satisfied after her feedings.

D. Imbalanced nutrition, more than body requirements

2. Which developmental task, according to Erikson, occurs during the adolescent period?

A. Autonomy

B. Initiative

C. Identity

Rationale: The developmental task of adolescence is to develop a sense of identity, or deciding who and what kind of person one is. RKC p108001-Knowledge

D. Industry

3. The nurse in the neonatal care unit notices that a term neonate has a respiratory rate of 66 breaths/min and exhibits pallor and lethargy. Which action does the nurse take **immediately**?

A. Unwraps the neonate and assesses for the presence of hypotonia.

Rationale: This is incorrect. The initial assessment findings of the neonate are indicative of cold stress. Hypotonia is also a manifestation of cold stress, and the condition can exacerbate cold stress. An immediate action by the nurse is not to unwrap the neonate.

B. Wraps the neonate in an additional blanket and puts a knitted cap on the neonate.

Rationale: This is correct. The initial assessment findings of the neonate are indicative of cold stress.

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Immediately, the nurse needs to take actions that will conserve body temperature. A knitted cap will cover the largest exposed area for heat loss; wrapping an additional blanket around the neonate will preserve heat.

C. Takes the neonate to the mother and assesses sucking reflex during a feeding.

Rationale: This is incorrect. An additional sign of cold stress is a poor sucking reflex. The nurse can assess for this manifestation in the nursery, and care should not be delayed by transporting the neonate to the mother for sucking evaluation. The immediate action is to decrease heat loss.

D. Contacts the neonate's health-care provider and seeks permission to take a rectal temperature.

Rationale: This is incorrect. Rectal temperature is obtained after birth to ascertain anal patency and is repeated only if prescribed by the health-care provider and then with great care. The nurse can obtain an axillary temperature. Immediate nursing actions are to decrease heat loss; additional assessments can be performed after efforts to preserve body heat.

4. The registered nurse (RN) in a pediatric office is preparing to administer oral medication to an infant. Before the actual administration of the medication, which **initial** action does the nurse take?

A. Obtain an accurate weight of the infant.

Rationale: This is correct. Pediatric dosing must be precise to ensure adequate therapeutic levels; dosing is based on weight. The weight needs to be obtained first.

B. Provide the caretaker with written information.

Rationale: This is incorrect. The caretaker will be provided with written information, but this action can take place before or after the administration.

C. Assist the caretaker in holding the infant supine.

Rationale: This is incorrect. The caretaker is asked to hold the infant during medication administration. The infant is held in a cradled position used for breast or bottle feeding. The infant is not laid in a supine position until after swallowing all the medication.

D. Acquire a calibrated syringe for administration.

Rationale: This is incorrect. The nurse carefully calculates the correct dose and draws the medication up in a calibrated syringe to ensure the exact dose is given. Caretakers are discouraged from using household spoons, because they vary in size and can result in over- or underdosing.

5. The nurse is interviewing a parent of a 9-month-old infant during a well-baby visit. Which statement by the parent causes the nurse concern about infant safety?

A. "He loves to get his toys out of a big plastic storage bag on the doorknob."

Rationale: This is correct. The nurse is concerned that the infant is getting toys out of a large plastic bag hanging on a doorknob. Plastic bags or wrappings are never kept where the infant can reach them because of the risk for suffocation or choking. If the bag is hung by a cord, there is an additional risk of choking.

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B. "He thinks the TV remote is a toy, so it is kept on a shelf too high for him to reach."

Rationale: This is incorrect. Swallowed batteries are a choking hazard and can cause serious damage to the gastrointestinal (GI) tract if swallowed. The nurse is not concerned because the TV remote is kept out of the infant's reach.

C. "When we eat cooked vegetables, I cut a few into bite-size pieces so he can try them."

Rationale: This is incorrect. An infant who is 9 months of age can be safely given cooked vegetables cut into small bite-sized pieces. Pieces that are too large or too small can present a choking hazard.

D. "It really disturbed me to see my neighbor's infant with a pacifier on a cord around the neck."

Rationale: This is incorrect. The parent's recognition that anything on a cord around an infant's neck is a choking hazard indicates an understanding about infant safety. The nurse can suggest that the information be shared with the neighbor.

6. The nurse in a community pediatric clinic screens for conditions that cause concern for possible infant abuse or neglect. Which situation will prompt the nurse to recommend parenting education?

A. The stay-at-home mother of four children (ages 4 to 16 years) who is bringing home a newborn

Rationale: This is incorrect. The stay-at-home mother of four children (ages 4–16 years) and a newborn does not cause the nurse concern about abuse or neglect.

B. The teenage couple with a newborn who live apart, but the father babysits during the day so the mother can attend school

Rationale: This is correct. The teenage couple with a newborn will cause the nurse the greatest concern about infant abuse or neglect. Because the couple live apart, the father is not exposed to the infant except when he is babysitting; unfamiliarity with the infant's behaviors or needs can lead to neglect. Frustration related to a lack of knowledge and/or immaturity places the infant at risk for abuse. The nurse needs to strongly recommend a program such as daddy boot camp to this couple.

C. The newly relocated couple with a young infant who are now 12 hours away from family and friends

Rationale: This is incorrect. The newly located couple with an infant will cause the nurse mild concern. Further assessment is needed regarding the mother's emotional and psychosocial needs. Technology allows close connections with family and friends who are located far away.

D. The parents of an infant who live apart because the father of the infant is married and has a family with his spouse

Rationale: This is incorrect. The volatility of the situation surrounding the birth of this infant may or may not cause the nurse concern over the risk of infant abuse and/or neglect. Further assessment is needed.

7. The nurse in a pediatric emergency department is concerned when parents bring a 9-month-old infant in for possible injury. X-rays indicate the infant has a broken leg. Which information causes the nurse to report possible physical abuse to the nursing supervisor? **Select all that apply.**

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Answers cannot be displayed for this alternate item format.

Rationale: Feedback 1. This is correct. Because of unexplained or repeated injuries such as welts, bruises, burns, fractured skull, broken bones, and especially spiral fractures, the nurse will report probable physical abuse to the nursing supervisor. 2. This is incorrect. Neglect of the child (e.g., dirty, undernourished, inappropriate clothes for the weather, lack of medical or dental care) is indicated when the parents insist on simple, noninvasive medical care for a known diagnosis, such as a broken leg. 3. This is correct. When the father states the infant climbed a stepladder and fell, the nurse will suspect physical abuse, because injury explanation is unlikely given the age or ability of the child. The nurse will report the situation to the nursing supervisor. 4. This is correct. Fearful or detached behavior by the infant, especially when the father talks, is a probable sign of physical abuse. The nurse will report the behavior to the nursing supervisor. 5. This is correct. Disagreement or inconsistency in the parent/caregiver explanation of the injury can be an indication of physical abuse. The nurse can seek clarification about details of the accident and/or inquire about injury to the mother during the fall. The nurse is likely to report probable physical abuse of the infant.

8. The nurse is evaluating the motor development of a preschooler at age 5 years. Which assessment finding is essential for the child to be considered ready for kindergarten?

A. Dresses independently

Rationale: This is incorrect. A preschooler is expected to dress and undress independently by age 5 years. Some assistance may be required for tying shoe laces; however, this is not an essential skill for entering preschool.

B. Uses the toilet without assistance

Rationale: This is correct. Before entering preschool, the preschooler needs to be able to use the toilet without assistance.

C. Draws stick figures with two or more body parts

Rationale: This is incorrect. A preschooler at age 4 years is expected to draw stick figures with more than two body parts. However, this is not an essential skill for a 5-year-old to enter preschool.

D. Throws overhand and catches a bounced ball

Rationale: This is incorrect. By the age of 4 years, most preschoolers can throw overhanded and catch a bounced ball. However, this is not an essential skill for a 5-year-old to enter preschool.

9. A parent has brought a toddler to a new pediatric clinic for a routine visit. The nurse will obtain a health history from the parent. Which information is **most** important for the nurse to gather?

A. Chief complaint

Rationale: This is incorrect. The information provided in this scenario indicates the visit is routine at a new pediatric clinic; there is not likely to be a chief complaint.

B. Family medical history

Rationale: This is incorrect. Family history (genetic disorders, chronic diseases, childhood cancers) is

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important; however, there is another choice that is most important.

- C. Toddler medical history

Rationale: This is correct. The most important health history information is the toddler's medical history, which will include childhood illnesses, hospitalizations, surgeries, immunizations, and results of vision/hearing/developmental screens.

- D. Social history

Rationale: This is incorrect. While the information will be included, the social history (living arrangements, day care/preschool, and behavior) is likely to be considered the least important during an initial visit.

10. The nurse in a pediatric office is performing physical assessments on multiple patients. Which patient will the nurse specifically report to the health-care provider because of physical assessment findings?

- A. The 4-year-old patient with a blood pressure of 110/75 mm Hg, pulse of 98 beats/min

Rationale: This is incorrect. The blood pressure and pulse rates for the 4-year-old patient are both within normal limits. The nurse does not need to specifically report these findings.

- B. The 3-year-old patient with a history of prematurely closed fontanels who has a headache

Rationale: This is correct. The 3-year-old patient with a history of prematurely closed fontanels has a condition that will affect the growth of the head. The presence of a headache is an indicator of possible increased intracranial pressure. Because there is a potential for brain damage, the nurse will report this finding specifically (and immediately) to the health-care provider.

- C. The 2-year-old patient with asthma who exhibits abdominal breathing at 26 breaths/min

Rationale: This is incorrect. Pediatric patients are normally expected to be abdominal breathers, and a respiratory rate of 26 breaths/min is normal for a 2-year-old patient. There is no reason for the nurse to specifically report these findings to the pediatrician. Symptoms related to asthma are absent.

- D. The 3-year-old patient with a soiled diaper, at the 70th percentile of weight and height

Rationale: This is incorrect. The 3-year-old patient who is in a soiled diaper and at the 70th percentile for weight and height may be exhibiting manifestations of neglect. The nurse may or may not specifically report these findings to the health-care provider. Another patient is at greater risk at this time.

11. The nurse is asking a parent of a toddler at age 18 months if there are any particular parenting challenges at this time. Which advice will the nurse offer if the parent shares issues with separation anxiety?

- A. The parent needs to just leave quickly and ignore the toddler's protests.

Rationale: This is incorrect. The nurse will not advise the parent to ignore the toddler's protests; this action is likely to increase anxiety.

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- B. The parent needs to keep reassuring the toddler that the parent will return.

Rationale: This is correct. The nurse will advise the parent to repeatedly reassure the toddler that the parent will be back. After the toddler is reassured, the parent needs to leave quickly.

- C. The toddler is to be left only with family members until the fear subsides.

Rationale: This is incorrect. The nurse will not advise the parent to leave the toddler only with family members; the fear and anxiety will eventually stop. Some parents do not have family members available to fill this need.

- D. The parent needs to plan leaving times to coincide with the toddler's naps.

Rationale: This is incorrect. Coordinating times to be away with the toddler's nap time will only cause a different type of anxiety. The toddler may resist napping because of fear the parent will leave while the toddler sleeps.

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12. The community pediatric nurses are making home visits to families who have children either above or below the normal ranges in weight and/or height. One nurse visits a home with three qualifying children under the age of 5 years who are all below the standards for their ages. Which interventions will the nurse introduce to the caretakers? **Select all that apply.**

Answers cannot be displayed for this alternate item format.

Rationale: Feedback 1. This is correct. The nurse will suggest the caregivers make food available for toddlers to eat approximately seven times a day, consuming more meals than snacks. 2. This is incorrect. Serving larger portions than recommended and/or pressuring a child to clean their plate can lead to overeating and increased risk for childhood obesity. Allow children to self-regulate intake while providing healthy, nutrient-filled choices. In addition, underweight children do not need to be overfed. 3. This is correct. Children should be allowed to graze throughout the day, as toddlers may not sit for three meals. 4. This is incorrect. Toddlers and preschoolers are not likely to cooperate with being fed. Children are encouraged to self-regulate their intake to promote a healthy intake of nutrient-filled choices. 5. This is incorrect. Introducing a variety of foods to children helps to broaden food choices. However, toddlers are also known to have "food jags," preferring to eat only one food over and over. This is a normal and self-limiting behavior.

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13. A school-aged child is being treated for an overdose of cough medicine administered by the parent. The child is 12 years of age and weighs 98 pounds. The label on the bottle states not to give the medication to children younger than 6 years, and provides a dosing chart that indicates an adult dose for children over 50 kg. For which reason does the nurse suspect the overdose occurred?

- A. The cough continued after being medicated.

Rationale: This is incorrect. There is no information in the scenario that indicates the cough medicine was ineffective.

- B. The parent misunderstood the weight parameters

Rationale: This is correct. The nurse suspects that the parent misunderstood the weight parameters for the medication. The parent may have thought 50 kg was another way of indicating 50 pounds and given the child an adult dose. Multiple doses caused an overdose.

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C. The parent measured with a household spoon.

Rationale: This is incorrect. Using a household spoon to administer liquid medication can cause either overdosing or underdosing with medication. There is no reference to the manner of measurement in the scenario.

D. The parent attempted to induce sleep in the child.

Rationale: This is incorrect. Some medications are capable of inducing sleep. There is no information in the scenario regarding the parent's intention other than the control of coughing.

14. The nurse is invited to present a program on child safety to parents of school-age children in the fourth and fifth grades. Considering the age, which information does the nurse include in the teaching plan?

A. Immunization schedule

Rationale: This is incorrect. Most states require that children receive specific immunizations prior to beginning school. The topic of immunization is not appropriate for a presentation on child safety.

B. Head injury prevention

Rationale: This is correct. Unintentional injury, including head injury, is the leading cause of death in this age group. Studies show that parents' knowledge of head injuries is limited. This information and the ages of the children makes this an important topic for the nurse to cover.

C. Age-appropriate toys

Rationale: This is incorrect. Concern about age-appropriate toys is most likely to be of interest to parents of children who are preschoolers and younger. However, the nurse plans to cover bicycle, scooter, skateboard, and sports safety in the presentation.

D. Symptoms of illnesses

Rationale: This is incorrect. Presenting the symptoms of illnesses may be important in a different presentation. The nurse needs to present information that is age appropriate and safety focused.

15. The school nurse is presenting information on the importance of exercise to children in the fifth and sixth grades of school. Which reason does the nurse cite as being the **best** reason for being physically active?

A. Sports provide an opportunity to bond with peers.

Rationale: This is incorrect. Encouraging participation in school exercise programs and available sports provides the opportunity for physical activity; however, it is not necessarily the most important action for bonding with peers, which is a psychosocial need. The nurse needs to emphasize the physical purposes and benefits of exercise.

B. Normal childhood activities make exercise fun.

Rationale: This is incorrect. Encouraging normal school-age activities, such as ball, jumping rope, bike

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riding, skating, and using playground equipment does make it fun to be physically active; however, the best reason for exercise and activity is the long-term impact.

C. Physical activity needs to replace technology hours.

Rationale: This is incorrect. Today's children are seriously immersed in the technological world, which makes promotion of physical activity more difficult. Technology is likely to always be a part of the younger generation's lives. Replacement is not reasonable; balance needs to be promoted.

D. Early exercise will carry over as good habits for adults.

Rationale: This is correct. As with nutrition, early education and experience with exercise can help to form good habits that can last a lifetime. This is the best reason for the nurse to promote physical activity, along with proven health benefits.

16. The nurse is gathering assessment data on a child who is 8 years of age and newly diagnosed with type 1 diabetes mellitus. The caregiver shares a reluctance to allow the child to return to school because the child's glucose levels need to be checked several times daily. Which information is **most** important for the nurse to share?

A. The caregiver may consider personally attending school with the child.

Rationale: This is incorrect. Personal caregivers can attend school with children who have multiple needs. The caregiver will benefit most from information that addresses the management of the child's condition within the school setting.

B. The child's medical condition is manageable in school and other places.

Rationale: This is incorrect. The nurse can provide information to the caregiver about methods to manage the child's medical condition in a variety of settings; however, management in school is the current concern.

C. The school nurse can care for the special needs of children in school.

Rationale: This is correct. Most children can be cared for at school by a school nurse. Medications for asthma and diabetes are commonly administered by the school nurse. This information will be most beneficial to both the child and the caregiver.

D. The caregiver is interrupting the psychosocial development of the child.

Rationale: This is incorrect. Informing the caregiver of interrupting the child's psychosocial development is untrue and places potential blame on the caregiver's concerns.

17. The school nurse attends a workshop focusing on the identification and prevention of bullying among school-age children. The nurse will be better able to identify both bullies and victims due to knowledge of which factors?
Select all that apply.

Answers cannot be displayed for this alternate item format.

Rationale: Feedback1. This is correct. The nurse will be able to associate poor academic achievement as a cause for either the bully or the victim.2. This is incorrect. Jealousy over sexual attention is not

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commonly recognized as a factor that contributes to the behavior of the bully; however, victims of bullying may be sexually abused.³ This is correct. The nurse will recognize that bullies and victims frequently have parents and caregivers with a high school or lower educational level.⁴ This is incorrect. Leader or follower personality traits can impact multiple areas of development in the school-age child. However, these traits are not specifically associated with bullies and their victims.⁵ This is correct. The nurse will recognize that poor health status, increased health needs, and mental health issues can be a factor in a child becoming either a bully or a victim.

18. The parents of an adolescent are distressed about the psychological changes in their child. Which example does the nurse validate as being a source of concern?

A. Constantly compares their body with others

Rationale: This is incorrect. It is characteristic of an adolescent to compare his or her body with the bodies of others. This is not a source of concern.

B. Comfortable with doing what the crowd does

Rationale: This is correct. Because impulsiveness and a sense of invincibility are common characteristics of the adolescent, the nurse will validate the parents' concern when the adolescent is comfortable doing what the crowd does.

C. Regularly tests family limits and rules

Rationale: This is incorrect. It is common for the adolescent to test family rules and limits. This is not always a source of concern.

D. Presents self in a constantly changing personae

Rationale: This is incorrect. "Trying on" different styles of dress, communication, and personae are common when the adolescent becomes interested in sexuality and gender roles. The nurse will encourage the parents to be supportive and patient.

19. The nurse is preparing to perform a physical examination of an adolescent who is 13 years of age. Which action by the nurse will decrease the adolescent's anxiety during the examination?

A. Teaching the anatomical names of body parts

Rationale: This is incorrect. The nurse should refer to body parts by the correct anatomical names; however, teaching the information to the adolescent is likely to cause embarrassment or anxiety.

B. Verbalizing findings of physical abnormalities

Rationale: This is incorrect. The nurse will focus on the positive aspects of the individual. The nurse needs to be cautious about pointing out physical abnormalities, which may cause the adolescent anxiety.

C. Referring patient concerns to the physician

Rationale: This is incorrect. The nurse is capable of addressing the adolescent's concerns directly;

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recommending the adolescent address a concern to the physician can cause anxiety.

- D. Telling the patient what to expect and why

Rationale: This is correct. The most effective way to decrease an adolescent's anxiety about a physical examination is to inform the adolescent of the nurse's actions and explain the rationales.

20. The nurse is collecting health data from a 16-year-old male patient. The patient states, "I need to tell you, I had sex with another boy, and I am very confused." Which comment by the nurse is **most** therapeutic?

- A. "You can share your thoughts and feelings with me."

Rationale: This is correct. The goal is to create an environment that makes the adolescent feel comfortable to discuss their concerns with the nurse. Therapeutic communication avoids opinions and judgments and attempts to explore the patient's thoughts and feelings.

- B. "Maybe you should speak with your parents."

Rationale: This is incorrect. Adolescents may not feel able to discuss personal matters with parents; the nurse's comment is likely to stop communication on the topic between the nurse and the patient.

- C. "Why were you attracted to this boy?"

Rationale: This is incorrect. Asking the patient why he was attracted to the other person is nontherapeutic and unnecessary.

- D. "Let's explore your feelings toward females."

Rationale: This is incorrect. Some adolescents identify themselves as gay, lesbian, or bisexual. When communicating with adolescents, do not assume heterosexuality. The nurse should not focus on the adolescent's orientation, because some adolescents may have had a same-sex experience and not be gay, and teens who identify as gay may have never had a same-sex experience.

21. The nurse is providing care for an adolescent patient who is hospitalized following a grand mal seizure. The condition has existed for 5 years and resulted in multiple hospitalizations. Which nursing intervention is appropriate for this client?

- A. Ask the patient and family to consider homeschooling.

Rationale: This is incorrect. It is most appropriate for the nurse to promote self-care and functional independence. The nurse can also coordinate services between health-care providers, school, and home.

- B. Arrange for home care and regular nursing visitations.

Rationale: This is incorrect. The patient does have a chronic condition, but the manifestations are unpredictable. Home care and/or nursing visitations need to be planned as, or if, needed.

- C. Explain methods to minimize the chronic medical events.

Rationale:

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This is incorrect. There may not be methods by which the patient and family can minimize the chronic medical events.

- D. Refer patient and family to applicable Internet resources.

Rationale: This is correct. The adolescent patient is likely to have an interest and the ability to do research on the Internet. To promote understanding through valid and applicable resources, the nurse needs to refer the patient and family to reliable Web sites.

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22. Nurses in pediatric emergency departments attend an educational program about identifying victims of human trafficking. Which characteristics have the nurses learned to identify? **Select all that apply.**

Answers cannot be displayed for this alternate item format.

Rationale: Feedback1. This is incorrect. Victims can include children, women, and men.2 This is correct. About 25% of human trafficking victims are minors. The average age is 12 to 14 years.3. This is correct. Poor health conditions among this population include STIs; urinary tract infections; multiple pregnancies, abortions, and/or miscarriages; injuries, skin conditions, burns, dental disease, malnutrition, and mental health issues with depression, anxiety, posttraumatic stress disorder (PTSD) and suicide attempts.4. This is correct. Many young women will have had multiple pregnancies, abortions, and miscarriages.5. This is incorrect. Mental health issues with depression, anxiety, PTSD, and suicide attempts are common for trafficking victims.

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23. The caregiver of a 4-year-old boy reports their son has voiced curiosity about their breasts. The caregiver asks the nurse what they should do. Which information is best for the nurse to give the caregiver?

- A. Advise the caregiver that sexual curiosity is unusual at this age

Rationale: Sexual curiosity is normal in the preschool-aged child.

- B. Encourage the caregiver to provide a detailed discussion about human sexuality with the child

Rationale: The parents should be encouraged to provide brief, honest answers to the child.

- C. Encourage the caregiver to determine what the child's specific questions are and answer them honestly

Rationale: The parents must also determine the type of curiosity the child has. Explanations should be within the level of understanding of the child. p1029 & 1041

- D. Advise the caregiver to explain to the child that they are too young to discuss such things

Rationale: Explanations should be within the level of understanding of the child.

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24. The nurse is discussing ways to promote discipline with parents who are becoming increasingly frustrated with their teenager. Which of the following would the nurse identify as MOST important?

- A. Establish rules and no expectations.

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B. Each parent determine consequences

C. Make your responses consistent.

Rationale: Consistency and predictability are the cornerstones of discipline. Establishing rules and expectations, collaborating to determine the consequences, and explaining the rules are all important, but they are not as important as being consistent. RKC p03-Application

D. Don't explain the rules to the adolescent.

25. A nurse is providing education to the caregivers of an infant about transitioning to solid foods. Why would the nurse advise that the caregivers try one new food at a time?

A. To establish the infant's likes and dislikes

B. To allow the infant's digestive system to accommodate to new foods

C. To give the infant's stomach enough time to adjust to different foods

D. To identify if the infant has any allergies to new foods

Rationale: When trialing new foods with an infant, it is important to do so one at a time so if the infant has any food allergies, it is clear what food item is causing the allergy.
