CLINICALJUDGE™ · NGN NCLEX STUDY GUIDE

NUTRITIONAL CONSIDERATIONS ACROSS THE LIFESPAN

Infant → Toddler → Preschool → School-Age → Adolescent → Older Adult → Pregnant Client. Safe vs. unsafe foods, priority nursing actions, and high-yield NCLEX traps for every stage.

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HEALTH PROMOTION & MAINTENANCE
BASIC CARE & COMFORT

#Lifespan #NCLEXTraps #Nutrition #Safety #Supplements #Pregnancy

LEGEND CRITICAL / UNSAFE · PATHOPHYSIOLOGY · SAFE / EXPECTED · COMPLICATIONS · NCLEX TRAPS · MEDS / SUPPLEMENTS · PATIENT EDUCATION

STAGE 01 · BIRTH – 12 MONTHS

INFANTS

kcal: 100–120 kcal/kg/day
Wt: doubles by 6 mo · triples by 12 mo

PATHOPHYSIOLOGY & NUTRIENT FLOW

Immature GI/renal/immune
Low gastric acid, ↑intestinal permeability

→

Liquid diet only 0–6 mo
Breast milk or iron-fortified formula

→

Fetal iron stores deplete ~4–6 mo
Iron-fortified cereal introduced first

→

Solids 4–6 mo
Tongue-thrust gone, head control, sits w/ support

✓ SAFE / EXPECTED

- **Breast milk** (preferred) × first 6 mo exclusively
- **Iron-fortified formula** if not breastfed
- **Vitamin D 400 IU/day** in breastfed infants (from days after birth)
- 4–6 mo: **iron-fortified single-grain cereal** (rice/oat) first
- 6–8 mo: pureed fruits, veggies, meats
- 8–12 mo: soft finger foods, mashed table foods
- **One new food at a time**, wait 3–5 days before next
- Peanut-containing foods introduced 4–6 mo (per AAP, reduces allergy)

✗ UNSAFE / AVOID

- **HONEY < 12 mo** → infant botulism (C. botulinum spores)
- **Cow's milk < 12 mo** → GI bleed, iron-deficiency anemia, renal solute load
- **Choking hazards:** whole grapes, hot dogs, popcorn, nuts, hard candy, raw carrots, raisins, chunks of peanut butter
- **No added salt/sugar** (immature kidneys)
- **Fruit juice < 12 mo** (AAP); ≤4 oz/day after
- Raw/undercooked meat, fish, eggs
- Goat milk, almond/rice milk as primary nutrition

- **Never prop bottle** or add cereal to bottle (aspiration, otitis media, choking)

PRIORITY NURSING LADDER

1. **Airway/aspiration:** upright feeding, no propped bottles
2. Verify formula prep (over-dilution → hyponatremic seizures; under-dilution → hypernatremia)
3. Monitor growth (weight, length, head circumference on CDC/WHO charts)
4. Reinforce iron source by 6 mo
5. Educate on developmental readiness for solids

IF → THEN CLINICAL RULES

- **IF** parent gives honey water for fussiness → **THEN** stop feeding, assess for hypotonia/poor suck/constipation (botulism)
- **IF** infant chokes on solid → **THEN** 5 back blows + 5 chest thrusts (no abdominal thrusts < 1 yr)
- **IF** breastfed infant < 6 mo → **THEN** 400 IU vitamin D supplement daily
- **IF** formula appears watery or scoops doubled → **THEN** re-educate parents; risk of water intoxication or dehydration

STAGE 02 · 1 – 3 YEARS

TODDLERS

kcal: 1,000–1,400/day
Milk: ≤24 oz whole milk/day

PATHOPHYSIOLOGY & NUTRIENT FLOW

Growth slows
Gains only 4–6 lb/yr

→

Physiologic anorexia
Expected; do not force-feed

→

Food jags & pickiness
Normal autonomy stage

→

Risk: milk-baby anemia
Excess milk displaces iron-rich foods

✓ SAFE / EXPECTED

- **Whole cow's milk** 12–24 mo (fat needed for brain growth)
- 2% or skim after age 2
- Small frequent meals: **3 meals + 2–3 snacks**
- Finger foods, soft cut-up table foods
- Iron-rich: fortified cereal, soft meats, beans, eggs
- Offer new foods 10–15× before rejection is "real"
- **Tablespoon per year of age** portion guide
- Family-style meals, model healthy eating

✗ UNSAFE / AVOID

- Choking hazards (cut grapes/hot dogs lengthwise, no popcorn/nuts/hard candy < 4 yr)
- **> 24 oz milk/day** → iron-deficiency anemia
- Juice > 4 oz/day
- Sugary drinks, soda
- Force-feeding or using food as reward/punishment
- Eating in front of TV / distracted
- Reduced-fat milk before age 2

PRIORITY NURSING LADDER

1. Reassure parents that physiologic anorexia is normal
2. Limit milk to 16–24 oz/day; emphasize iron-rich foods

IF → THEN CLINICAL RULES

- **IF** toddler drinks 32 oz milk & refuses food → **THEN** screen Hgb/Hct, educate on milk cap 24 oz

3. Screen Hgb at 12 mo (CDC) for iron-deficiency anemia
4. Teach choking-hazard list and Heimlich for ≥ 1 yr
5. Plot growth percentiles each visit

- **IF** parent says "won't eat" → **THEN** assess intake over 7 days, not single meal
- **IF** picky food jag (only nuggets x 2 wks) → **THEN** reassure; continue offering variety without coercion
- **IF** Hgb < 11 g/dL → **THEN** oral iron + vitamin C; expect dark stools

STAGE 03 · 3 – 6 YEARS

PRESCHOOLERS

kcal: 1,200–1,800/day
Milk: 2 cups low-fat/skim

PATHOPHYSIOLOGY & NUTRIENT FLOW

Slow steady growth
~4.5 lb & 2.5 in/yr

→

Imitates family eating
Modeling shapes lifelong habits

→

Iron, Ca, Vit A/C/D risk
If diet is restricted

→

Dental caries risk peaks
Sugary snacks, juice in cups

✓ SAFE / EXPECTED

- Follow **MyPlate**: fruits, veggies, grains, protein, dairy
- Low-fat or skim milk (≥ 2 yr)
- Whole grains, lean proteins, soft fruits
- Involve child in shopping/prep (autonomy)
- Routine meal/snack schedule
- Cut grapes/hot dogs lengthwise until age 4–5
- Water as primary drink between meals

✗ UNSAFE / AVOID

- Sugar-sweetened beverages, soda
- Juice > 4–6 oz/day (AAP)
- High-sodium / processed snack foods as staples
- Choking hazards still apply (whole nuts, hard candy, popcorn < 4 yr)
- Using food as bribe or punishment
- Clean-plate club / forced consumption

PRIORITY NURSING LADDER

1. Assess BMI percentile; plot growth
2. Screen for food insecurity & access
3. Reinforce MyPlate & consistent mealtimes
4. Promote dental hygiene (caries link)
5. Educate parents: parent decides *what/when/where*, child decides *how much*

IF → THEN CLINICAL RULES

- **IF** BMI ≥ 85th %ile → **THEN** family-based lifestyle counseling, not restrictive dieting
- **IF** only eats white/beige foods → **THEN** screen for ARFID; offer pairings, no pressure
- **IF** parent reports caries → **THEN** stop sippy cup w/ juice at night; refer to dental

STAGE 04 · 6 – 12 YEARS

SCHOOL-AGE

kcal: 1,600–2,200/day
Ca: 1,000–1,300 mg · Fe: 8–10 mg

PATHOPHYSIOLOGY & NUTRIENT FLOW

Steady growth
~5–7 lb & 2 in/yr

→

Bone mineralization accelerates
Calcium needs ↑ near puberty

→

Peer / media influence
Marketing of sugary cereals, snacks

→

Obesity risk window
Sedentary + processed snacks

✓ SAFE / EXPECTED

- Balanced breakfast — improves cognition & behavior
- Calcium-rich foods (dairy, fortified plant milks, leafy greens)
- Whole grains, lean protein, fruits/veggies
- Healthy snacks: yogurt, fruit, cheese, hummus
- Pack school lunches; involve in planning
- Water 6–8 cups/day; milk with meals
- Physical activity ≥ 60 min/day

✗ UNSAFE / AVOID

- Skipping breakfast
- Sugary drinks, sports drinks, sodas
- Excessive screen-time eating
- Energy drinks / caffeine (limit < 100 mg/day if any)
- Diet pills, restrictive dieting
- Fast food as routine

PRIORITY NURSING LADDER

1. BMI percentile screening yearly
2. Encourage breakfast, family meals
3. Education on portion sizes, label reading
4. Refer for nutrition counseling if BMI ≥ 95th %ile
5. Screen for body-image concerns early

IF → THEN CLINICAL RULES

- **IF** child skips breakfast → **THEN** link to school free-breakfast program
- **IF** BMI ≥ 95th %ile → **THEN** family lifestyle interventions, not isolation diets
- **IF** child reports "fat" comments → **THEN** screen for early eating-disorder symptoms

STAGE 05 · 12 – 18 YEARS

ADOLESCENTS

kcal: 2,200 (F) – 3,000 (M)/day
Ca: 1,300 mg · Fe: 15 F / 11 M mg

PATHOPHYSIOLOGY & NUTRIENT FLOW

Growth spurt
↑ kcal, protein, all micronutrients

→

Peak bone-mass deposition
Calcium + vit D + weight-bearing activity

→

Menarche → ↑ iron loss
Risk: iron-deficiency anemia in females

→

Body-image & autonomy
Eating-disorder risk window

✓ SAFE / EXPECTED

✗ UNSAFE / AVOID

- Calcium 1,300 mg/day (peak bone mass!)
- Iron-rich foods: red meat, beans, fortified cereal, leafy greens
- **Folate** for all females of childbearing age
- Protein for muscle/growth (~52 g M / 46 g F)
- Hydration — especially athletes
- Healthy snacks accessible at home
- Vegan/vegetarian: ensure B12, iron, zinc, omega-3

- Fad / restrictive diets (keto, juice cleanse) during growth
- Skipping meals — particularly breakfast
- Energy drinks & high caffeine (cardiac arrhythmia risk)
- Diet pills, laxative misuse, self-induced vomiting
- Alcohol
- Excess fast food / sugary beverages
- Steroids / unregulated supplements (athletes)

PRIORITY NURSING LADDER

1. Screen for eating disorders (SCOFF, weight trends, amenorrhea)
2. Assess Hgb/Hct, especially menstruating females
3. Reinforce calcium + vit D for peak bone mass
4. Confidential nutrition counseling — independence valued
5. Address sport / supplement / energy-drink misuse

IF → THEN CLINICAL RULES

- **IF** female athlete + amenorrhea + low BMI **→ THEN** female athlete triad → urgent referral
- **IF** rapid weight loss + lanugo + bradycardia **→ THEN** suspect anorexia nervosa
- **IF** normal weight + binge/purge + dental erosion **→ THEN** suspect bulimia
- **IF** sexually active female **→ THEN** 400 mcg folic acid daily (pre-conception NTD prevention)

STAGE 06 · 65+ YEARS

OLDER ADULTS

kcal: 1,600-2,200/day
Protein: 1.0-1.2 g/kg · Ca 1,200 mg · Vit D 800-1,000 IU

PATHOPHYSIOLOGY & NUTRIENT FLOW

↓ BMR & lean mass
Sarcopenia → ↑ protein need

→

↓ Thirst, ↓ saliva, ↓ taste/smell
Dehydration & poor appetite

→

Atrophic gastritis
↓ B12 absorption

→

Polypharmacy & dysphagia
Drug–nutrient & aspiration risks

✓ SAFE / EXPECTED

- ↑ Protein 1.0–1.2 g/kg/day (sarcopenia prevention)
- Calcium 1,200 mg + Vit D 800–1,000 IU
- B12-fortified foods or supplement
- Fiber 21–30 g/day (constipation)
- Fluids 1,500–2,000 mL/day unless restricted (HF, CKD)
- Small frequent meals; nutrient-dense
- Soft, moist textures if poor dentition
- **Thickened liquids** if confirmed dysphagia (per SLP)

✗ UNSAFE / AVOID

- Thin liquids if aspiration risk
- **Grapefruit juice** (↑ statins, CCBs, immunosuppressants)
- High-sodium processed foods if HTN / HF
- **Variable vitamin K intake** if on warfarin (keep *consistent*, don't avoid)
- Alcohol with sedatives, opioids, hypoglycemics
- Tyramine-rich foods (aged cheese, cured meats) if on MAOIs
- Skipping meals — leads to weight loss & frailty

PRIORITY NURSING LADDER

1. **Aspiration risk first** — HOB ≥ 30°, swallow eval if indicated
2. Weigh weekly; ≥ 5% loss in 1 mo = significant
3. Reconcile meds for nutrient interactions
4. Hydration plan — schedule, not thirst-driven
5. Refer to dietitian, dental, SLP, social work as needed

IF → THEN CLINICAL RULES

- **IF** coughing during meals + wet voice → **THEN** stop PO, NPO, SLP swallow evaluation
- **IF** on warfarin → **THEN** teach *consistent* green-leafy intake (do NOT eliminate)
- **IF** on levodopa → **THEN** separate from high-protein meals (competes for absorption)
- **IF** dehydrated + thin liquids ordered → **THEN** verify swallow status before pushing fluids
- **IF** taking MAOI → **THEN** tyramine restriction (no aged cheese, cured meats, draft beer)

STAGE 07 · PRENATAL

PREGNANT CLIENTS

+340 kcal (2nd tri) · +452 kcal (3rd tri)
Folate 600 mcg · Fe 27 mg · Ca 1,000 mg · Protein 71 g

PATHOPHYSIOLOGY & NUTRIENT FLOW

↑ Plasma volume + RBC mass
Physiologic anemia; iron need ↑↑

→

Neural tube closes by day 28
Folate *before* conception

→

Fetal skeleton
Calcium pulled from mother if deficient

→

↓ Immune tolerance
Listeria, toxoplasma, salmonella risks ↑

✓ SAFE / EXPECTED

- **Folic acid 400 mcg pre-conception, 600 mcg in pregnancy**
- Iron 27 mg/day (prenatal vitamin)
- Calcium 1,000 mg/day (1,300 if < 19 yr)
- Protein 71 g/day
- **Low-mercury cooked fish** 8–12 oz/wk: salmon, sardines, shrimp, canned light tuna, tilapia, cod
- Well-cooked eggs, pasteurized dairy/juice
- Weight gain: BMI normal 25–35 lb · underweight 28–40 · overweight 15–25 · obese 11–20
- Caffeine ≤ 200 mg/day (~12 oz coffee)

✗ UNSAFE / AVOID

- **Alcohol — NO safe amount** (FAS)
- Raw/undercooked fish, sushi, meat, eggs
- Deli meats & hot dogs *unless reheated to steaming* (Listeria)
- Unpasteurized milk, cheese, juice
- Soft cheeses unless labeled pasteurized: brie, feta, blue, queso fresco
- **High-mercury fish: shark, swordfish, king mackerel, tilefish, bigeye tuna**
- Raw sprouts (alfalfa, clover, radish)
- Liver / retinol (excess Vit A → teratogen)
- Herbal teas not cleared by provider
- Cat-litter cleaning, raw garden soil (Toxoplasmosis)

PRIORITY NURSING LADDER

1. Confirm prenatal vitamin started & tolerated
2. Screen Hgb/Hct each trimester (1st & 3rd minimum)

IF → THEN CLINICAL RULES

- **IF** client reports persistent vomiting + weight loss → **THEN** screen hyperemesis gravidarum, check

3. Educate on food-borne illness prevention
4. Plot weight gain pattern by pre-pregnancy BMI
5. Refer high-risk diets (vegan, PKU, GDM, bariatric history) to RD

ketones/electrolytes

- **IF** GDM dx → **THEN** 3 meals + 2–3 snacks; complex carbs; limit simple sugars
- **IF** Hgb < 11 g/dL (1st/3rd) or < 10.5 (2nd) → **THEN** iron supplementation, take w/ vit C, NOT w/ milk/calcium
- **IF** seizure hx on phenytoin → **THEN** ↑ folate (drug depletes folate)
- **IF** craving non-food items (ice, clay, starch) → **THEN** pica → screen iron-deficiency anemia

KEY LABS & NUTRITIONAL MARKERS

Memorize the cut-offs and the *why*. NGN often pairs a lab with an age-specific finding.

Lab / Marker	Normal Range	Population	NCLEX Significance
Hgb	11–15 g/dL (peds)	Toddler / school-age	↓ = IDA; screen at 12 mo; limit milk to 24 oz
Hgb (pregnancy)	≥ 11 (1st/3rd) · ≥ 10.5 (2nd)	Pregnant	Physiologic dilution; supplement if below
Ferritin	20–250 ng/mL	All	Best indicator of iron stores; low = depletion
Albumin	3.5–5.0 g/dL	Older adults	↓ = chronic malnutrition; long half-life
Prealbumin	15–36 mg/dL	All	Acute changes (½-life ~2 d); refeeding response
Vitamin B12	200–900 pg/mL	Older adults / vegans	Atrophic gastritis ↓ absorption → neuro sx
Vitamin D (25-OH)	30–100 ng/mL	All; especially older & infants	↓ = ↑ falls, rickets, osteoporosis
Folate (serum)	> 5.4 ng/mL	Pregnancy / women of CB age	↓ = NTDs, macrocytic anemia
Fasting glucose	< 95 mg/dL (pregnancy)	Prenatal (GDM)	Screen 24–28 wk; carb-controlled diet if elevated
BMI percentile	5th–85th %ile	Peds & teens	≥ 95th = obesity; < 5th = underweight
% Unintentional wt loss	> 5% in 1 mo / 10% in 6 mo	Older adults	Significant — full nutrition assessment, refer RD

⚠ 8 NCLEX TRAPS — LIFESPAN NUTRITION

1. Honey < 12 mo
Wrong: "small amount is fine for cough."

2. Cow's milk < 12 mo
Wrong: 2% after 9 mo.
Right: Breast/formula × 12

3. Warfarin + greens
Wrong: avoid all vit-K foods.
Right: *Consistent* intake — don't eliminate.

4. Deli meat in pregnancy
Wrong: cold turkey sandwich OK.

Right: Zero honey under 1 yr — botulism.

mo. Then whole milk 12–24 mo.

Right: Reheat to steaming — Listeria.

5. Folate timing
Wrong: start after positive test.
Right: 400 mcg *before* conception — NTDs close day 28.

6. Adolescent calcium
Wrong: less than adult need.
Right: 1,300 mg/day — peak bone mass.

7. Cereal in bottle
Wrong: helps baby sleep.
Right: Never — choking, aspiration, otitis, obesity risk.

8. Grapefruit + elderly meds
Wrong: harmless juice.
Right: ↑ levels of statins, CCBs, immunosuppressants, some BZDs.

NCLEX PATTERNS — STEM CUES → CORRECT ACTION

"Cough, wet voice during meal" (older adult) → NPO, SLP swallow eval, HOB ≥ 30°.

Infant, 9 mo, "just gave honey-water" → assess hypotonia, weak cry, constipation → suspect botulism.

Female athlete, amenorrhea, low BMI → female-athlete triad → urgent referral; not just "eat more."

Preschooler refuses dinner → reassure parent; offer same food next meal without coercion.

Older adult on MAOI orders cheese plate → hold tray, educate tyramine list, notify provider.

Toddler drinks 32 oz milk/day, picky eater → screen Hgb, cap milk at 24 oz, ↑ iron foods.

Pregnant + tuna salad sandwich → which fish? canned *light* tuna OK ≤ 12 oz/wk; avoid albacore > 6 oz/wk.

Older adult on warfarin starts kale smoothies daily → check INR, teach consistency (not avoidance).

Pregnant w/ pica (ice / clay) → CBC, ferritin → iron-deficiency anemia work-up.

Adolescent vegan, fatigue, pallor → check Hgb, B12, ferritin → supplement & food sources.

NGN BOW-TIE · CLINICAL JUDGMENT SUMMARY

Unfolding case: A 32-yr G2P1 at 28 wks, BMI 24, reports "always tired," craving ice chips. Diet: skips breakfast, deli sandwich + soda for lunch, dinner with family. PMH none. Hgb 9.6 g/dL · Ferritin 9 ng/mL · Fasting glucose 102 mg/dL.

ACTIONS TO TAKE

- Start oral iron + vitamin C
- Educate on heme + non-heme iron foods
- Stop cold deli meats unless reheated steaming
- Order 3-h GTT (FBG ≥ 95)
- Limit caffeine ≤ 200 mg/day
- RD referral for GDM-prep diet plan

PRIORITY CONDITION

IRON-DEFICIENCY ANEMIA W/ PICA + R/O GDM

PARAMETERS TO MONITOR

- Hgb/Hct & ferritin in 4 wks
- Weight-gain pattern
- Fasting + 1-h post-prandial glucose
- Pica resolution
- Fetal growth / fundal height
- Energy & fatigue self-report

PATIENT & FAMILY EDUCATION CHECKLIST

- ☐ **Infants:** Breast milk or iron-formula × 6 mo · NO honey, cow's milk, juice < 12 mo
- ☐ **Adolescents:** Peak bone mass — calcium + vit D · screen ED · folate if female

- □ **Toddlers:** Cap milk at 24 oz · cut grapes/dogs lengthwise · expect picky eating
- □ **Preschoolers:** MyPlate plate model · involve in prep · routine snacks
- □ **School-age:** Eat breakfast · limit sugary drinks · build calcium habits
- □ **Older adults:** Protein at every meal · scheduled fluids · review meds & food interactions
- □ **Pregnancy:** Prenatal vitamin · no alcohol · avoid raw/unpasteurized · low-mercury fish only
- □ **All ages:** Hand hygiene before meals · safe food handling · culturally tailored teaching

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